Hepatitis C Prevention Education for Injecting Drug Users in Australia

A research report

by

G.W. Dowsett, L. Turney, G. Woolcock, A. Rance and N. Thomson

Australian Research Centre in Sex, Health & Society
La Trobe University, Melbourne

A collaborating Centre to the National Centre in HIV Social Research

July 1999

ISBN 1864464917
DEDICATION

This report is dedicated to the memory of

Geoffrey Fysh

8 January 1959 — 4 January 1999

Geoffrey was a valued community activist, skilled educator and trusted friend, whose untimely death robbed Australia of one of our most important HIV/AIDS and related diseases community resources—Geoffrey himself.
PREFACE

The hepatitis C epidemic in Australia is the focus of this report. In its concern with preventing the transmission of the hepatitis C virus (HCV), this research report examines Australia’s efforts to date in prevention education particularly among people who inject drugs. The research was commissioned by the Commonwealth Department of Health and Aged Care and undertaken by the Australian Research Centre in Sex, Health and Society (ARCSHS) in collaboration with the National Centre in HIV Social Research.

The research team included Gary Dowsett (principal investigator), Lyn Turney and Geoffrey Woolcock (research fellows), Tony Rance (educator/researcher seconded from the New South Wales Users and AIDS Association), Nicola Thomson and Liz McDonnell (project assistants) and Damian Hunter (volunteer).

Additional assistance was provided by ARCSHS staff members: Anthony Smith, Anne Mitchell, Doreen Rosenthal, Diane Shannon, Lee Marquardt and Liz Wyld.

An advisory committee was established to support the project, consisting of the research team and Jude Byrne (Australian IntraVenous League), Timothy Costigan (community sector member), Marcelle George and, initially, Alan Thorpe, then by Eamonn Murphy (Commonwealth Department of Health and Aged Care), David McInnes (University of Western Sydney, Nepean) and Anne Mitchell (ARCSHS). The Terms of Reference for the advisory committee are provided in Appendix 1.

The research team are very grateful for the assistance and support provided by other ARCSHS staff members and the advisory committee. Thanks also to the New South Wales Users and AIDS Association and Annie Madden for supporting the project by allowing Tony Rance to be seconded to the project.

In addition, a large number of agencies in the public and community health sector gave generously of their time to provide information about their hepatitis C prevention efforts among injecting drug users. On behalf of the research team, may I thank those agencies and their hard-working educators for their willingness to assist us in this research.

This research report is presented to the Commonwealth Government in the hope that it will contribute to Australia’s efforts at hepatitis C prevention by enhancing our understanding of the importance and effectiveness of health educators and their efforts on behalf of Australia’s injecting drug users.

Gary Dowsett
Associate Professor & Deputy Director
Australian Research Centre in Sex, Health and Society
Faculty of Health Sciences, La Trobe University Melbourne, July 1999
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EXECUTIVE SUMMARY

This research project was undertaken in the second half of 1998 with a view to examining the character and extent of hepatitis C prevention education being undertaken in Australia particularly among injecting drug users (hereafter, ‘HCV/IDU prevention education’).

The study consisted of four components:
• an Australian and international literature review;
• a series of initial consultations with interested agencies in each State and Territory;
• a national activity survey of agencies undertaking HCV/IDU prevention education;
• a series of key stakeholder interviews.

In addition, an action research project undertaken in collaboration with educators in three agencies was conducted over a three-month period.

The research revealed that there is a large amount of HCV/IDU prevention education going on in Australia, mainly geared to offering injecting drug users (hereafter, ‘users’) information about the hepatitis C virus (HCV), its major routes of transmission and how to prevent that transmission. However, it is also clear that injecting drug users face a range of related health issues that require an educational response broader than hepatitis C prevention alone, and that improving HCV/IDU prevention education across the sector will best be achieved in the context of broader health education programs for users. Many agencies are already delivering educational programs beyond a focus on HCV transmission and other services beyond prevention education. These efforts are important and need to be encouraged by new initiatives in developing programs and by providing better training programs for educators in the sector.

The provision of information on hepatitis C occurs in a diverse range of agencies in the sector from large public health services and correctional services departments to small non-governmental organisations, some of which are focused on hepatitis C and others which offer a range of services such as needle and syringe provision programs or work in related fields such as HIV/AIDS organisations. It is clear that the sector is not as coordinated and does not possess a sense of identity as a sector in the way that gay men’s agencies in Australia, for example, have developed a clear sense of the scope of their HIV/AIDS work and of the other players in that sector. This diversity of agencies will require a multifaceted approach in any further policy and programmatic initiatives developed to enhance the sector’s efforts at HCV/IDU prevention education. The capacity of these agencies to enhance their current programs will require an examination of their basic infrastructure needs. There is a great deal of willingness on the part of educators to improve their educational programs, but there are currently significant resource and infrastructure constraints on their capacity to effect change.
The educators are developing a wide range of educational styles and activities in an effort to meet the growing needs of users and they utilise an impressive range of evaluation methods to assess their effectiveness. However, there are difficulties in matching evaluation methods appropriately to educational activities and the overarching hepatitis C education curriculum is in need of additional systemisation and development. This report recommends a number of initiatives designed to improve the curriculum framework of hepatitis C education and to strengthen the workforce of educators in the sector to provide even better HCV/IDU prevention education. The major mechanism to achieve this is the institution of a HCV Education Curriculum Development Unit for a three-year period. Its major activities and focus are detailed below.

Finally, a number of small research needs have been identified that will enhance the sector’s awareness of its target populations and strategic approaches. These utilise an action research approach in the main and seek to encourage the sector to undertake research and become involved in research that focuses more on its educational needs.

In all, there is good educational practice occurring across Australia in HCV/IDU prevention education. This provides a substantial basis for Australia’s efforts at hepatitis C prevention among users through enhanced health education. There is room for improvement but much to work with in order to achieve this.
SUMMARY OF RECOMMENDATIONS

R1. We recommend that a national infrastructure benchmarking study be undertaken, particularly in the community-sector agencies and the NSPs to assess the basic resource requirements for supporting the educational activities of the sector.

R2. We recommend the development of a national HCV Educator Training Agenda (HETA), based on a range of processes: on-the-job activity; short courses; and competency and credentialled courses where appropriate. To achieve this, we recommend a demonstration training project be developed specifically to test models of on-the-job training, particularly for the community sector agencies and NSPs. This would operate alongside any other training initiatives in the national training agenda.

R3. We recommend a new ethnographic research project, undertaken with user groups along action research lines, to identify and explore a number of predominant IDU subcultures in at least three sites. The project will explore recent shifts in ‘ways of using’, and develop simple research and analysis techniques for identifying ‘ways of using’ in local contexts, which would be useful to educators as one tool for assessing target audiences and local needs.

R4. We recommend that the national infrastructure benchmarking project (see recommendation 1 above) take the issue of program management and coordination as one major focus.

R5. We recommend that HCV/IDU prevention education be contextualised conceptually and in practice within a broader framework of IDU health education.

R6. We recommend the enhancement by the Commonwealth Department of Health and Aged Care of its Hepatitis C Website, one that not only provides guaranteed accuracy in its information, but which also actively intervenes in discussions and debates on the Internet to ensure that informal channels of information are monitored, linked and, if necessary, challenged.

R7. We recommend two short research projects using rapid assessment techniques to (1) evaluate print suitability and usage among identified cohorts of users using existing print materials and (2) investigate potential usage of alternative and interactive media, such as the Internet, video and other electronic technology more suitable to particular subcultures of users.

R8. The encouragement of a more systematic style of educational program design and development in the sector will be well served by establishing a portable short course on
program design as part of the national training agenda. It is recommended that this be a *practice-based* course, i.e. working with educators *in situ* on real programs, rather than taught in abstract.

R9. We recommend an *outreach development project*, run as a demonstration project to be undertaken along action-research lines, which will document and develop outreach as a specific HCV/IDU pedagogy.

R10. We recommend the establishment of an HCV Education Clearing House (HECH) project whose activities include the development of a National Hepatitis C Manual.

R11. To achieve this, we recommend that the HECH should be sited within an HCV Education Curriculum Development Unit (HECDU), established for a three-year period and based in the national HCV/IDU agencies, which will outline the core curriculum in HCV/IDU prevention education and undertake a series of activities detailed in a number of subsequent recommendations in this report.

R12. We recommend that the development of a range of practice-based ‘client assessment tools’ be one important task for HECDU (and also be one of the research aims in the *ways of using* research project in recommendation 3).

R13. We recommend a short HCV/IDU project determining appropriate education programs for health professionals to (a) identify the key elements of those education programs to be provided by user educators, (b) develop a short course for training user educators to provide education programs for health professionals, and (c) provide accreditation to user educators trained to provide such education.

R14. We recommend the establishment of a three-year HCV Education and Information Support Team (HEIST), as the core staff of HECDU, to work with educators and agencies on requests to, for example, develop new client assessment tools, renovate existing projects, improve resource production, plan formative evaluation to improve programs, encourage reflexive practice activity, and work alongside the agency educators for a period in a targeted or focused pedagogy development activity.

R15. To support this work, and in addition to HEIST salaries and associated administration costs, it is recommended that an HCV Education Innovation Resources (HEIR) fund be established to foster small modelling or pilot projects that might be used throughout the sector.

R16. We recommend a ‘community development’ modelling project be established in HECDU to provide specific support for the sector in determining practices, processes and evaluative techniques to be used in community development aspects of hepatitis C education.
R17. To encourage better evaluation processes (in addition to the initiatives in program design recommendation above), we recommend establishing a two-year evaluation matching project, based in HECDU, one which fosters a more selective use of evaluative techniques better matched to the educational aims and behavioural objectives of a given intervention.

R18. We recommend that funding agencies be encouraged to allocate 10% of funding to any program or project in future to develop reflexive practice (not just but including evaluation) in that program or project.

R19. We recommend that funding be provided to support the establishment and use of an hepatitis C interagency model on local levels, particularly focused on education whether for prevention or health maintenance and treatments purposes.

R20. We recommend the funding of a NSP-based HCV/IDU prevention education development project to work specifically on developing practice-based strategies for enhancing educational activities in NSPs nationally.

R21. We recommend the Commonwealth Department of Health and Aged Care initiate the collaborative development of a Pharmacy Hepatitis C Education Project, to complement any existing training available to pharmacists, with a view to producing enhanced educational strategies targeted at users and suitable to pharmacy-based delivery and circumstances.

R22. We recommend as a starting point a brief national consultative project that collects a draft research agenda for circulation and discussion, and that this forms the basis of submission to whatever research coordination development mechanism is outlined in the forthcoming National Hepatitis C Strategy.
Schematic Summary of Recommendations

**CONTEXTS:**

R5. Broad educational framework for injecting drug use health education

R18. 10% of program/project funds to be allocated to develop reflexive practice

R19. Development of and support for interagency infrastructure

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**R11. HCV EDUCATION CURRICULUM DEVELOPMENT UNIT**

(three-year program to develop core curriculum)

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GLOSSARY

AIDS Acquired Immune Deficiency Syndrome
AIVL Australian IntraVenous League
ANCARD Australian National Council on AIDS and Related Diseases
ARCSHS Australian Research Centre in Sex, Health & Society
BBV Blood-Borne Viruses
CEIDA Centre for Education and Information on Drugs and Alcohol (Sydney)
CALDB people from Culturally and Linguistically Diverse Backgrounds
Commonwealth Health Commonwealth Department of Health and Aged Care
GP General Practitioner
HCV Hepatitis C Virus
HIV Human Immunodeficiency Virus
IDU Injecting Drug Use (the field or domain of such drug use)
NIROA Non Injecting Routes of Administration
NUAA New South Wales Users and AIDS Association
PLWHA People Living With HIV or AIDS
QuIVAA Queensland Intravenous AIDS Association
SCIVAA Sunshine Coast Intravenous AIDS Association
STI Sexually Transmissible Infections
TASCARD Tasmanian Council on AIDS and Related Diseases
TUHSL Tasmanian Users Health and Support League
User a person who injects drugs
Using that act of drug injection
VDHS Victorian Department of Human Services
WASUA Western Australian Substance Users Association
WRAP Western Region AIDS Prevention
1

Introduction

1.1 Background

The incidence of hepatitis C virus (HCV) infection in Australia has reached alarming levels, with some 11,000 new cases estimated to have occurred in 1997. Hepatitis C infection was scheduled as a notifiable disease in 1990. Between 1991 and 1997 there were over 110,000 cases reported to the National Notifiable Diseases Surveillance System. Estimates of the prevalence of hepatitis C infection in Australia are around 190,000. Approximately 80% of notified cases of hepatitis C infection in Australia have occurred as a result of injecting drug use (hereafter ‘IDU’). Presently, IDU remains the most likely mode of hepatitis C transmission through the sharing of contaminated injecting equipment, and is estimated to account for approximately 90% of new infections. (Hepatitis C Projections Working Group 1998)

The rate of HCV infection among injecting drug users (hereafter ‘users’) is not uniform (Selvey et al. 1996). Significant factors found to be associated with hepatitis C infection include: duration of injecting (Carruthers et al. 1997; Garfein et al. 1996; Selvey et al. 1996), prison history (Butler et al. 1997; Carruthers et al. 1997; Crofts et al. 1995; Crofts, Thomson et al. 1996), new injectors (Garfein et al. 1996; Smyth et al. 1998), and opiate injectors (Carruthers et al. 1997; Selvey et al. 1996).

This extensive infection comes after nearly two decades of struggle in Australia to prevent the epidemic of HIV infection from reaching the alarming proportion among users it has reached in other countries, a struggle that has been largely successful. Indeed, cumulative HIV incidence to 30 September 1998 related specifically to IDU is 4.5% (National Centre in HIV Epidemiology and Clinical Research 1999) and prevalence of HIV infection and or AIDS among users has been low and stable for over a decade.

The very success of preventing widespread HIV infection among users at one level renders the prevalence of hepatitis C infection all the more puzzling. The detail of the HCV epidemic in Australia and the impact on users particularly is not the subject of this report. Other reports are readily available to offer that detail (Lowe & Cotton 1999; New South Wales Legislative Council Standing Committee on Social Issues 1998; Hepatitis C Projections Working Group 1998). It is sufficient to say here that the hepatitis C epidemic has caused government, researchers and user organisations to examine Australia’s current efforts in public health programs for users and to re-think
the current processes and programs that have clearly worked in relation to HIV but may be missing their mark on hepatitis C.

The Hepatitis C Subcommittee of the Australian National Council on AIDS and Related Diseases (ANCARD) at a meeting in 1998 discussed a number of educational initiatives that might *inter alia* address the issue of re-gearing hepatitis C prevention education. One difficulty that confronted the Subcommittee was that no-one knew the complete picture of hepatitis C prevention education for users happening in Australia, or exactly who was undertaking it and how that work was being carried out. An investigation was needed to map the sector of prevention education in relation to hepatitis C transmission and injecting drug use (hereafter ‘HCV/IDU prevention education’).

It was not only the HCV/IDU prevention education activities being undertaken that needed to be mapped. It was clear that the educators undertaking those activities were already active in the field designing and developing programs. We needed to know how they were doing that, and how they were evaluating their efforts and trying to improve on their success. This idea of ‘success’ was important, because some decrease in hepatitis C incidence was becoming apparent (Hepatitis C Projections Working Group 1998); securing that declining rate with even better prevention education was clearly an important and immediate task.

The National Centre for Disease Control in the Commonwealth Department of Health and Aged Care (hereafter, Commonwealth Health) took up the idea of the Subcommittee and developed a brief to undertake a national review of current HCV/IDU prevention education programs and of HCV/IDU educators’ evaluation techniques. In late May 1998, Commonwealth Health commissioned the Australian Research Centre in Sex, Health and Society (ARCSHS) at La Trobe University, Melbourne, to undertake that review.

In designing this as an educational research project, an additional component was added to the Commonwealth Health brief—an action-research project, intended to explore the possibility of working with and alongside HCV/IDU educators to observe and document in more detail their educational thinking, planning and daily practices.

The project began in August 1998. Staff were recruited and the fieldwork began in earnest in September and finished in the third week of December 1998. Analysis of data was undertaken from January to early May 1999, and this report to the Commonwealth was completed in July 1999 after an initial report-back session at the First National HCV Educators Workshop held in Canberra on 20-21 May 1999.

### 1.1.1 Why is this an educational research project?

It is now commonplace to refer to non-biomedical and natural science research in HIV/AIDS and related diseases (and in other fields as well) as ‘behavioural’ or ‘social and behavioural’ research. This terminology in part refers to the significant role behavioural surveillance plays in monitoring risk practices and behavioural change in various populations affected by these diseases. Using the term ‘social’ as well as
‘behavioural’ registers that other kinds of inquiry offer useful information on aspects of a society’s experiences of health problems other than behavioural ones, e.g. the way in which social class affects sexuality and safe sex (Connell et al. 1991).

Educational research, however, specifically focuses the actions of educators and their clients or audiences. It also seeks to explore the ways in which public health education programs, activities and initiatives are developed, enacted and assessed for effectiveness, with a view to understanding the pedagogy of health education and the development of its curriculum. By pedagogy we mean the ‘art or craft of the teachers’ and all that is involved in their creation and delivery of health education programs, activities and initiatives. In this case, our focus on the work of HCV/IDU educators, particularly those working in prevention education. By curriculum we mean the overall body of knowledge and the suite of programs on offer in the sector, in this case HCV/IDU prevention education.

This kind of research sees the educators as the key ingredient in successful health education, and argues that understanding how these educators work and what they create is an essential component of any attempt to assess and improve the educational outcomes achieved (see also Connell 1985; Shaw & Dowsett 1986; McInnes et al. 1999). In effect, educational research of this kind is intended to complement behavioural research and its concern with outcomes in relation to the consumers of educational programs, and to add to models of behavioural change and health promotion the active ingredient often left out of their modelling—the educators who create the very educational moments that produce these outcomes. In essence, the argument is that unless all the inputs are well understood and then supported, the outcomes are not really comprehensible.

### 1.2 Methodology

With this educational framework in mind, this research project sought to document HCV/IDU prevention education in Australia from two perspectives: (1) mapping the sector to see what agencies, organisations and institutions were active in the field; and (2) obtaining a picture of the full field of educational activities under way. A methodology was devised consisting of four related methods:

- a literature review;
- an initial consultation (or a rapid assessment process);
- a national survey of agencies and their activities in HCV/IDU prevention education;
- in-depth interviews with key stakeholders.

In addition, the action-research component was added to explore the possibility of using this kind of research methodology to investigate the pedagogy of HCV/IDU prevention educators in a more interactive and embedded way.
1.2.1 Literature review

A review of the Australian and international literature was undertaken and involved the use of the major electronic academic databases. The full literature review is provided in Section 2 of this report. In brief, the review found that, although there is a good deal of information about hepatitis C, there is considerably less about IDU and hepatitis C. The literature on hepatitis C transmission and/or education consists mainly of prevention education for health care workers, primarily in the workplace. The literature on IDU and prevention focuses almost entirely on the transmission of HIV. There is a significant absence of literature about HCV/IDU prevention education.

Materials collection

It was intended that other materials from existing HCV/IDU prevention education interventions from Australian sources be collected and catalogued to try and produce a typology of principal pedagogic modes and evaluation strategies being used in Australia. This proved unachievable. While considerable material was collected—in the main small media and some video—great diversity, in educational terms, was not found. Information provision was the key educational purpose of most material, perhaps reflecting the stage that hepatitis C prevention is at in Australia (and not dissimilar to the early period of HIV prevention education in the mid-1980s). This is not, in itself, a problem. It simply meant that the variety of pedagogical techniques expected from materials collection was not to be found through this method. The survey, however, achieved much of the intention originally planned for the materials collection process and offers a more complex picture of significant and varied pedagogy.

A second issue confounding the materials collection method was the impossibility at times of separating out HCV/IDU prevention education from materials that formed part of multi-focused educational activities for users. Some of these combine hepatitis C and HIV issues or are designed to deal with safer-using issues and hepatitis C and/or HIV infection, or vein care. It was often difficult to disentangle user education from HCV/IDU prevention education—and so it should be, according to many of the key stakeholders interviewed. This inseparability was confirmed by the finding in the survey that 63% of HCV/IDU prevention education activities were not costed separately from other activities undertaken by the agencies involved.

In other words, the embeddedness of much HCV/IDU prevention education in broader programs and services for users, such as equipment provision, client assessment and referral, or counselling, etc., rendered ineffective the materials collection and analysis process as originally designed, and it became clear that any potential typology of pedagogies in this emerging field was as yet undefinable. The materials collected, however, are not wasted and could form the basis of a clearing house, a hepatitis C archive, and/or resources for future training programs (see Recommendations).
1.2.2 Initial consultations

As part of the initial consultation process, a series of visits was undertaken by research staff over the first three months of the project. The primary purpose of these consultations was to map the ‘territory’ of HCV/IDU prevention education in Australia, in an attempt to identify and enumerate the agencies who might be eligible to participate in the survey, and also to seek potential agency partners for the key stakeholder interviews and the action research. Most of these consultations were face-to-face meetings, but a small number were conducted by telephone. The agencies, dates and persons participating in the consultations are listed as Appendix 2. A summary of issues that arose during these initial consultations is presented in Section 3.

1.2.3 The survey

The key instrument for investigating the current state of play in HCV/IDU prevention education in Australia was a national survey by self-administered questionnaire of nominated public and community sector agencies delivering HCV prevention education for users. The questionnaire was developed by research staff with the assistance of the advisory committee and piloted in a small number of agencies in Victoria. The criteria for inclusion in the survey were also set on the advice of the advisory committee, e.g. correctional services were to be included, generalised community health services were not. The list of agencies by type which were sent the survey is detailed in Appendix 3.

The survey was divided into two parts as a result of that development process and piloting: one questionnaire for the agency undertaking the HCV/IDU prevention education (Agency Questionnaire); a second questionnaire (Activity Questionnaire) that allowed each individual prevention activity undertaken by that agency to be documented. The results of the survey are presented in Section 4 of this report.

1.2.4 Key stakeholder interviews

The initial consultations with agencies were undertaken with government, non-government and academic institutions. These consultations delineated a set of issues that were then explored in depth in the subsequent key stakeholder interviews and enabled us to: contextualise the survey findings; identify the key needs associated with improving educational program planning, delivery and evaluation; and obtain an account of efficacy, sustainability and the policy/philosophical framework or underpinnings of the programs. The key stakeholders were all very experienced workers in the field and came from a broad range of agencies. A total of twenty-two key stakeholder interviews were conducted in all States and Territories with selected lead agencies.
Ethics approval

Ethics approval for the project was obtained from La Trobe University, and this approval was granted on the understanding that the identities of the key stakeholder interviewees would remain confidential. Therefore, the analysis of the key stakeholder material presented in this report does not identify the respondent or his/her organisational base.

1.2.5 Action research projects

This last phase of the research project was intended to assist in deepening the understanding of Australia’s HCV/IDU prevention education programs. It was hoped that, in conjunction with other elements in the project, the action research component might contribute to beginning the development of ‘models’ in HCV/IDU prevention education by providing a number of key principles in educational intervention and evaluation that will offer potential direction for the Commonwealth Government’s future public health programs for users.

Another advantage of employing action research, as a kind of demonstration project, was to check on the feasibility of this research technique as a future component in educational research in the sector. The possibility of action research processes being used in health education is worth exploring, because in the very process of participating in the reflective activities of the research the agencies gain more than a documentation of their practice to date. They actually develop improved strategies in the light of that reflection and a better understanding of what they do well. Such an approach can produce a joint sense of ownership of research (or, for that matter, evaluation) and ensures that any recommendations will have both the support of those agencies and a ‘do-ability’ that improves uptake. The report of the action research reveals considerable potential for this methodology.

Each agency involved in the action-research component was asked to allow a research fellow and/or the seconded educator/researcher (hereafter, research staff) to participate in selected education programs, working with the agency’s educators in a collaborative process of investigation, reflection and development, and to assist in identifying key aspects of good educational practice in HCV/IDU prevention education. The action-research component of the project ran for a three-month period, from October to December 1998.

1.2.6 The methodology as a whole

The methodology was designed to capture as efficiently as possible an overall picture of HCV/IDU prevention education in Australia. The initial consultations assessed the sector’s boundaries and set the agenda for further exploration in the survey and the key stakeholder interviews.

A number of agencies approached for the survey did not return questionnaires. Sometimes this occurred because they were doing no HCV/IDU prevention education;
in other cases, there were overlaps and we had already contacted the actual site of the activity occurring. Some agencies declined to participate or did not return questionnaires in time for data analysis. In a few cases, decisions to participate were delayed internally by the agencies and finally precluded their involvement. Therefore, this report cannot describe all the HCV/IDU prevention education occurring in Australia right now. However, the spread of agencies in each identified part of the sector, the number of returned questionnaires, and the information obtained through the initial consultations and in-depth interviews offer more than enough to describe the national effort with confidence.

Findings from the literature review, initial consultations and the survey will be reported in turn. Then an overview of the action-research component will be presented, while the detailed reports from the three individual action-research projects can be found in Appendix 5. There is no separate section devoted to the findings of the key stakeholder interviews as such. In the process of analysing the interview material, findings merged with, and expanded on, those from other parts of the methodology. Therefore, in Section 6 a full analysis of all findings is integrated into a single discussion, along with recommendations for improving prevention education practice in the HCV/IDU sector.
2

Review of Australian and International Literature

2.1 Introduction

The international and Australian literature was reviewed specifically to identify existing effective and innovative educational interventions aimed at preventing transmission of HCV among people who inject drugs. The review of the literature involved the investigation of the following electronic databases: Austrom, Current Contents, Medline Express, PsychINFO, Sociofile, Healthline, Cinahl, ABI/INFORM, and Fulltext Nursing. In addition, there was regular monitoring of AIDSNEWS, and abstracts and papers were reviewed from the First Australian Hepatitis C Conference and the XI and XII World AIDS Conferences in Vancouver and Geneva respectively.

The literature on hepatitis C is largely dominated by clinical studies and epidemiological information about the virus, its incidence and spread. The prevention and/or education literature consists mainly of prevention education for health care workers, primarily in the workplace, and is beyond the brief of this report. The studies and reports about IDU and hepatitis C are, in the main, studies of users and the context of using, and provide some important material relevant to the understanding of the delivery of hepatitis C virus prevention education and access to, and understanding of, various target groups. These include the Fitpack Study on hidden drug injectors (Lenton & Quigley-Tan 1997); stigmatisation and discrimination experienced by those infected with hepatitis C (Crofts et al. 1997); the importance of contextual and cultural factors in safe injecting (Crisp 1996; Hankins 1998; Louie et al. 1998; Orr & Leeder 1998); reasons for needle-sharing and cultural preference in not injecting (Choi et al. 1996); risk-taking behaviours among young injectors (Louie et al. 1996); initiation to injecting (Crofts, Louie et al. 1996); the absence of ‘negotiated safety’ in injection-sharing equipment (Dear 1995); and the inability to inject oneself and resultant dependency on others to do it (Hankins 1998).

There are also informative studies evaluating the success of needle and syringe programs (NSP) for the prevention of transmission of blood-borne viruses (BBV)—although, HIV was the focus of the majority of these studies. The results of a study conducted in San Francisco showed that introduction of NSP did not stimulate an increase in rates of injecting or recruitment of new and/or young users (Watters et al. 1994). Another study showed the importance but impracticability of supplying all US injectors with syringes for each injection and recommended maximising efforts by
targeting high-risk users and creating new prevention strategies (Heimer 1998). Finally, there were studies showing a decrease in sharing in, for example, the Bronx, New York City (Schoenbaum et al. 1996), Tasmania (Lucas & Easthope 1996), New Zealand under a ‘user-pays’ system (Nimmo 1995), and Hong Kong (Choi et al. 1996).

Lowe and Cotton (1999), in their review of Australia’s national hepatitis C response for Commonwealth Health, noted that there has been insufficient social and behavioural research to guide the development of education and prevention programs. Also, Sykes (1996), in a comprehensive review of social research into hepatitis C and IDU, outlined gaps identified by researchers and asked some key questions about prevention education for users:

- Where users are most likely to receive drug-using information?
- How is innovation and education diffused through users’ networks?
- Are education models and learning styles that we use appropriate to the lives of those who inject drugs?
- How do we educate users who are not in touch with drug treatment agencies?
- What peer education programs/information are available?
- Is testing for HCV accompanied by appropriate education messages?

Apart from these references however, a thorough search of the literature revealed a dearth of information about HCV/IDU prevention education that actually outlines the techniques of education used in practice, although some studies do discuss the content of education or educational materials used.

2.2 The need for hepatitis C prevention education

Prevention of the spread of hepatitis C is seen to be the key to controlling the virus—particularly as treatment options are limited and ‘transmission appears to follow minimal breaches of infection control guidelines’ (Wodak 1997:275). Although there has been a decline in HIV incidence since the introduction of NSP, users continue to share needles, syringes and other equipment, and the continuing high HCV infection incidence rate indicates that the current output and reach of prevention education strategies is not sufficiently effective (Lowe & Cotton 1999). While prevention education is crucial, it appears that the challenge of getting HCV/IDU prevention messages across is a particularly complex one for several reasons.

First, the content of the prevention education messages is not as straight-forward as the relatively simpler messages of HIV prevention (although certainly equally difficult to convey educationally in terms of the modes of transmission). The most important prevention messages, particularly for users, ‘will have to be doubly laboured for hepatitis C to address the greater potential for infection’ (Orr & Leeder 1998:194). For
users, ‘education campaigns should focus on the minutiae of drug injection practices, where infection has a high chance of occurring’ (p. 194).

Second, the task is made more difficult by the fact that injectors are not a homogeneous group, so prevention education messages have to account for considerable diversity in the target audiences. Orr and Leeder, for example, contrast the stereotypical ‘junkie’ with body builders, and note that prevention messages targeted at the former would be inappropriate for educating ‘body worshippers, muscle men and women’ (1998:194). In fact, inappropriate prevention messages are actively resisted, especially those which demonise injecting and drugs, as they appear to users to give a falsely negative view of what is mostly a pleasurable experience (Loxley & Davidson 1991).

Moreover, it has been seen as difficult in the hepatitis C field to employ public health approaches based on the concept of ‘partnership’ as used in HIV. Orr & Leeder (1998) argue that there is not an easily defined, politically aware and able community to partner with, nor one to champion the cause of HCV/IDU prevention. Injecting drug users lack the ‘strong identity, appeal, and cohesiveness of the gay community’ (Orr & Leeder 1998:193). Undoubtedly, user groups, with the support of the Australian IntraVenous League (AIVL) since 1989, have already made a start in building a more cohesive community response among users, but representative partnerships require innovative ways of accessing this diversely constituted and rather shapeless sector.

Third, the accessibility of the target groups or individuals who have little in common apart from their injecting is particularly problematic. Injecting drug users are a diverse group both geographically and socially, and having no identifiable coherent community makes access and targeted education a difficult process (Lowe & Cotton 1999). In their study of functional injecting drug users, Sharp et al. (1991) stated that the only two things that individual drug users have in common is their drug use and their experience of stigma. Further, the size of the functional drug user population was estimated to be several times greater than the number of dysfunctional drug users who are more usually identifiable through their contact with police and treatment agencies (Duckett 1995).

Fourth, the illicit nature of IDU makes it difficult to provide broad-based information (such as education in schools) to ensure different target groups are reached before they engage in practices that place them at enhanced risk of contracting HCV. Further, hepatitis C as a disease is currently misunderstood by many (Orr & Leeder 1998), and disclosure often meets with misunderstanding about the risk to friends, family members and associates, and to victim blaming (Palmer 1999). The illicit nature of IDU also means that there is limited available evidence on what constitutes ‘good practice’ in using and in educational initiatives in relation to it (Lowe & Cotton 1999).

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1 Functional drug users are ‘those who believe their lives are not affected in any obviously adverse way by their drug use and for whom drug use may not be central to their definition of themselves’ (Duckett 1995:73).
Although the National Drug Strategic Framework 1998-2002 (Intergovernmental Committee on Drugs and the Australian National Council on Drugs 1998) makes many general recommendations addressing the issue of illicit drugs, it makes no specific recommendations in relation to hepatitis C prevention education, or education about safer injecting. The report recommends *inter alia*: school-based education programs; the development and distribution of information products; community development projects; peer education; skills building and employment programs; and prevention programs to be delivered in appropriate environments such as youth centres, prisons, employment agencies, gyms and liquor outlets. Given that the Framework clearly identifies young people and initiates as desired targets of prevention education, it would seem important that protocols and methods of education are spelled out urgently.

### 2.3 Main groups ‘at risk’ for HCV infection

One focus of the literature is on identifying those most at risk of hepatitis infection, thereby delineating the target populations most appropriate for educational programs. These populations are: young initiates; Indigenous Australians; people from culturally and linguistically diverse backgrounds (CALDB); and prison populations.

#### 2.3.1 Young initiates

Various researchers argue that prevention education programs should be directed towards frequent injectors and should emphasise the identification and counselling of new and young injectors (Crofts, Louie et al. 1996; Hansen et al. 1996; Lenton & Quigley-Tan 1997; Loxley 1998; MacDonald et al. 1998). A study of high-risk young people in Perth about knowledge of hepatitis C found that, although more than 80% of the young drug users had heard about hepatitis C and were at risk of infection through unsafe injecting practices, only half of them considered the infection to be a serious problem (Carruthers & Loxley 1995). A Melbourne study on young initiates reported that ‘substantial proportions were not aware of hepatitis C’ (Crofts, Louie et al. 1996:1195). The authors recommended appropriate and well-aimed peer outreach education programs for young people and young initiates as the key to prevention.

Loxley (1998) also suggests that constraints to education need to be identified and strategies developed for overcoming such barriers, as well as finding ways of reducing risk-taking behaviours.

A recent study in the United States reported figures from the Centers for disease control that showed a huge decrease in new hepatitis C infections from 180,000 in 1984 to 28,000 in 1995. The researchers suggest that, although the institution of NSP in some areas may be partially responsible, decreasing IDU and prevention L

However, Madden (reported in Wood 1996) argues that a focus on young users wrongly implies that the drug-using population is neatly segregated when, in fact, initiation may involve users of different age cohorts and the attendant transfer of
established injecting practices. Researchers in Baltimore observed that users who injected their first time alone or with someone more than five years older had increased hepatitis C infection rates, and concluded that prevention targets should always include experienced users (Garfein et al. 1998). Crofts, Louie et al. (1996) also reported 76% of their Melbourne sample of young initiates to have first injected with older people.

2.3.2 Indigenous Australians

The Intergovernmental Committee on Drugs and the Australian National Council on Drugs (1998) state the need for community ownership of the ‘drug problem’ and community participation in dealing with it, especially in the communities of Aboriginal and Torres Strait Islanders (hereafter Indigenous Australians).

The authors of a Community Report of the Victorian Aboriginal Health Service state that, although there is a need for more and better education about hepatitis C, when indigenous Australian users were desperate for a ‘fix’, injecting the drug expeditiously took priority over the potentiality of becoming infected. In fact, the long-term onset of hepatitis C makes it less of an individual concern among Indigenous Australians, because most of them do not believe that they will live for much longer than twenty more years (Edwards et al. [nd]). There are also issues about the fraught nature of harm reduction and the pervasiveness of the abstinence model in indigenous communities in Canada (Landau 1996) and Australia (Hunter 1996), and the need for self-determination in drugs policy (Gray 1996). It would appear that harm reduction as a principle of action seems, so far, to have been poorly conveyed to Indigenous Australians (Brady 1996).

2.3.3 People from culturally and linguistically diverse backgrounds

The National Hepatitis C Councils Education Reference Group (1996), which undertook a needs assessment of people with hepatitis C in Australia, was not able to access CALDB people to ascertain their specific needs. They found that the most common method of assistance was to make hepatitis C information available in languages other than English, i.e. making translations of existing materials and recorded educational messages on telephone help lines. There was no discussion about the cultural appropriateness of the educational materials or messages themselves. Hepatitis C is widespread in several Mediterranean countries as a result of mass vaccination programs in the 1950s and 1960s, and there is also a high prevalence of the virus among people from the Indochinese region. In both instances, because of the stigma associated with hepatitis C and the linkages with illicit activity and drug users, people do not come forward to seek information, testing and assistance.
2.3.4 The prisons population

Prisons are particularly high-risk environments for hepatitis C transmission due to over-representation of users among inmates and the non-availability of sterile injecting equipment (Butler et al. 1997; Commonwealth Department of Health and Family Services 1996; Cregan et al. 1997; Cregan 1998; Crofts et al. 1995; Crofts, Thompson et al. 1996; Darke et al. 1998; Denton 1992; Fennie et al. 1996; Lior et al. 1998; Mohanty & Biswas 1996; Robinson 1994; Swan 1998; Turnbull et al. 1996). Prisoners in each jurisdiction receive at least some hepatitis C prevention education (Lowe & Cotton 1999), but this needs to be accompanied by access to clean injecting equipment, which, although highly recommended, is not currently available (Cregan et al. 1997; Burrows 1996b). This is the case because prisoners themselves are seen as high-risk instead of the environment of prisons and are the ‘worst served by harm minimisation programs’ (Cregan 1998: 7), despite those programs’ effectiveness elsewhere.

Groups already at-risk are doubly vulnerable to contracting hepatitis C in prisons, in particular young offenders (Prendergast 1997) and Indigenous Australians (Cregan et al. 1997; Edwards et al. [nd]; Prendergast 1997). Sending young and indigenous people to prison does not stop them from using drugs and, for many, it is in prison that their injecting begins (Edwards et al. [nd]). However, while vulnerable groups are often harder to reach with prevention education messages unless they identify with them (Prendergast 1997), peer education in juvenile justice systems has been shown to be particularly effective because identification with a peer enables credibility, trust and belief in the prevention information.

2.3.5 People with hepatitis C

Health education strategies should also be aimed at those already infected because, although they develop antibodies to hepatitis C, they do not become immune, and can be infected and reinfected many times and, as a consequence, suffer most seriously of all from the effects of the virus (van der Poel 1994). Van der Poel also states that prevention messages never become redundant, as people with hepatitis C are both potential sources and casualties of the virus.

2.4 The policy context for prevention education

2.4.1 Harm reduction

Harm reduction or harm minimisation is an established principle in the approach to drugs in Australia and has proven a very effective strategy in reducing the transmission of HIV (Young 1992). Lenton and Single (1998:219) define harm reduction as follows:
A policy, program or intervention should be called harm reduction if, and only if: (1) the primary goal is the reduction of drug-related harm rather than drugs per se; (2) where abstinence-oriented strategies are included, strategies are also included to reduce harm for those who inject drugs; and (3) strategies are included which aim to demonstrate that, on the balance of probabilities, it is likely to result in a net reduction of drug-related harm.

The policy of harm minimisation was broadened by the *National Drug Strategic Framework 1998-2002* to include a wide range of approaches for dealing with drug problems, including initiatives aimed at: preventing the uptake of drug use through education and law enforcement; abstinence-oriented initiatives aimed at reducing drug use; interventions aimed at reducing the supply of illicit drugs; and a variety of strategies aimed at reducing the consequences of drug use (Intergovernmental Committee on Drugs and the Australian National Council on Drugs 1998).

Burrows (1996a) argues that these strategies and Australia’s successive national HIV/AIDS strategies contain contradictory policies that actually work against each other. The drug strategies depict people who inject drugs in a negative, stigmatising way while focusing mainly on illicit drugs. Further, the drug strategies are biased towards the negative effects of drugs and refuse to acknowledge accounts of the positive or enjoyable aspects of illicit drug use, which, according to Loxley (reported in Burrows, 1996a:21), recognise the personal experience of users who find it ‘fun, recreational, undertaken carefully, and has little apparent harmful outcome (other than it is illegal)’.

Lowe and Cotton (1999) report that the apparent decreased political commitment to harm minimisation as an effective strategy in relation to illicit drugs and BBV may mean there will be a lack of willingness to implement more effective approaches in this area, which they insist are essential if hepatitis C is to be controlled in Australia.

Despite its apparent limitations, a policy of harm minimisation has been successful in enabling an infrastructure of standard prevention services such as NSP (Burrows 1996c; Lowe & Cotton 1999). A further advantage is that AIVL, other community-based user groups and Hepatitis C Councils have also been resourced to a certain extent. However, Lowe and Cotton go on to argue that ‘increased funding for national community-based organisations...could make the national effort much more effective.’ (1999:137).

Finally, if it is thought that Australia’s commitment to harm minimisation is wavering somewhat, this is not the case elsewhere, such as India (Burrows 1997; Deany & Crofts 1997) and the Asia-Pacific region (Crofts & Wodak 1996), where Australia’s successes to date using harm minimisation are regarded as an example of good practice.

### 2.4.2 Non-injecting routes of administration

Within the broader policy context of harm minimisation, there are researchers, such as Crofts (reported in Wood 1997), who argue for less restrictive approaches such as
minimising needle phobia by normalising and deregulating the sale of syringes to make them readily available in supermarkets and convenience stores. Wodak (1996) claims that the policies of prohibition and harm reduction are minimalist approaches that will not work in controlling hepatitis C and suggests a more controversial approach that is aimed at eradicating the injection of drugs rather than drug use per se by a switch to non-injecting routes of administration (NIROA) as the best strategy in controlling hepatitis C and overdose deaths.

The possibility of effecting such a shift is supported by a study conducted by Choi et al. (1996), who reported a shift to inhalation among drug users attending a methadone clinic in Hong Kong. But the health risks of smoking heroin, ‘speed’ and other drugs have not been evaluated, and people such as asthmatics may be safer injecting than smoking (Madden, reported in Wood 1996). Byrne (reported in Wood 1996) argues that introducing a policy recommending change to non-injecting routes of administration sets up injecting itself as the problem rather than injecting practices, and will add to the discrimination already experienced by users and further marginalise them, making disease prevention more difficult.

2.4.3 Peer-based education

Within the HCV prevention education field, there is strong argument for peer education as the preferred mode of delivery, but little discussion as to why and how peer education works. For example, Crofts, Louie et al. (1996) argue that peer education programs are likely to be the most effective harm-reduction approach among new injectors, because using is based on a conformity to a peer group and is a more common explanation for initiation than the stereotype of active recruitment by a drug dealer. In this sense, the initiate is an active participant in a set of negotiations between peers.

The notion of peer-based interventions in IDU is already well developed in the HIV/AIDS prevention literature. Peer education and peer support have been shown to be effective as methods of risk reduction in HIV prevention in user communities in, for example, the Netherlands (Trautmann 1995), the United States (Broadhead et al. 1996; Friedman 1987; Friedman et al. 1993; Hughes et al. 1998; Wood & Rhodes 1996), the United Kingdom (Jones 1990; Power et al. 1995; Power et al. 1996), and in Australia (Crofts & Herkt 1995; Loxley & Davidson 1991; Marsh & Loxley 1992). It is from this literature that the rationale for a centrality for peer-based approaches to BBV transmission prevention is often drawn.

A peer-driven intervention relies on active collaboration with users rather than a ‘provider-client’ model and is based on the theory of ‘group-mediated social control’, which works by:

altering people’s...preferences regarding how others should behave...It does this by using...rewards and punishments to a group based on the performance of individual members. A [peer-driven intervention] works by...providing direct rewards to members for eliciting positive responses from their peers. (Broadhead et al. 1996:543)
Inside information, knowledge from personal experience and trust are key factors in the success of peer education initiatives (Friedman 1987; Friedman et al. 1993). Within the peer group, self-disclosure can be a springboard to successful education, and experience suggests that the most important feature of peer education and support are the social influences on drug users’ attitudes toward safer behaviour and growth in users’ self-efficacy through role-modelling initiatives (Friedman 1992; Friedman et al. 1993). ‘The fact that peers are familiar with peer-group norms, and that peers are easier to trust for drug users, helps the conveyance of reliable information about risk behaviour’ (Trautmann 1995: 618).

There are, however, differences between concepts of peer education and peer support, which often get conflated (Trautmann 1995). Education implies and emphasises an inequality between the educator and the educated, so peer education purposively aims to have users teach each other the rules of safer using. In contrast, Trautmann argues that peer support implies mutual support, shared experience and equality, and is a broader concept that has the goal of not only influencing behaviour but also creating better conditions for safer behaviour such as access to sterile syringes and needles.

In the peer education model, the focus is also on mobilising peer pressure within users’ broader social networks to reinforce health-oriented behaviours. Such networks are characterised by functionally supportive and reciprocal relationships, and peer education and advocacy generally take place on an informal basis and are often promoted by established members and key figures in social networks (Power et al. 1995).

Power et al. also argue that, because risk reduction is part of the lifestyle of drug injectors, the rules operate to the good of the whole and are quite responsive to peer education. Therefore, intervention models should take into account and incorporate the positive coping strategies that are already being practised by target groups. Such norms are already focused toward empowering drug injectors, therefore they can more readily be mobilised in the task of adopting and sustaining desired behaviour change.

The social network approach implies that providing opportunities for social peer interaction in prevention is as important as the content of prevention information itself (Trautmann 1995). The potential for drug dealers, who often collect quantities of clean injecting equipment for distribution to users, to be important health advocates could be usefully exploited (Power et al. 1995).

However, in examining the effectiveness of HIV risk-reduction education, Hughes et al. (1998) reported peer groups also to be an obstacle to behaviour change. He argues that ‘when drug injection is embedded in social ties and habits of social use, [users] inject more often, and the effectiveness of risk-reduction education is significantly lower than for [users] who tend to inject by themselves’ (1998:4). He concluded that intervention efforts will be likely to have greater effect on solitary users, and that users should be actively encouraged to extract themselves from social injecting and to stop living with partners who inject (1998). Power et al. (1995) also acknowledges that, within peer groups and networks, certain activities and attitudes have negative consequences for harm minimisation. These are minority concerns in a literature that
more often strongly supports peer-based interventions, even if the essence that makes peer-based interventions actually successful is elusive.

There is some argument for a role for ‘affected’ communities in hepatitis C prevention work (Hulse 1997; Lowe & Cotton 1999; Orr & Leeder 1998; Stimson & Rhodes 1997), and this carries with it the assumption that peer educators in the HCV/IDU field are likely to be users or ex-users. Finally, it was noted that peer-based user groups have been influential in an advisory capacity to governments, especially in the development of educational and harm-reduction programs (Crofts & Herkt 1995).

### 2.5 Hepatitis C prevention education interventions

A small part of the literature reviewed pertained to accounts of educational programs, either as reviews, reports or evaluations. We include here those aspects of that material relevant to the educational issues involved, and in particular would note the extent of peer participation embedded in these interventions. It is, by now, almost standard practice in Australia to include users (current or ex-) in IDU-focused health education.

#### 2.5.1 TRIBES - health promotion

The TRIBES projects, auspiced at New South Wales Users and AIDS Association (NUAA), engage in health promotion to ‘functional’ drug users. The projects consist of a series of activities to provide HIV and hepatitis C prevention education to a wide range of carefully targeted, otherwise difficult to access groups or ‘tribes’. Each project is coordinated by a peer educator and targets a particular social network. Through the development of prevention education materials or activities, it addresses both individual behaviour and the social context that defines the norms relating to the behaviour. The resources developed by the TRIBES projects are seen not as ends in themselves but rather as a ‘strategy for raising discussion about and influencing the individual’s and group’s social norms’ (Duckett 1995:78). Further, they are only useful while they contain current and relevant information that is deemed worthy of distribution to the target ‘tribe’. The sustainability of the resource itself is ultimately less important than the fact that its development will have gathered key people together over a period of time to change knowledge, attitudes and behaviour (Duckett 1995:78; NUAA 1996).

In her evaluation of the TRIBES project, Duckett (1995) argues that perhaps the most important aspect in the success of these ‘one-off’ projects is that each employs a ‘tribe’ member/peer as the project worker and has ‘tribe’/peer representation on its project steering committee. Also, the greatest predictor of success were those projects that had a optimal balance of involvement between ‘tribe’ members and professional service providers.
2.5.2 The peer education project

The Hepatitis C Peer Education Project comprises a series of projects that employ peer educators to develop resources, mainly in Victoria, and has targeted networks of rural users and, more recently, users in urban Footscray, the focal suburb of Melbourne’s western region. This project has, at its core, provision of one-to-one counselling education sessions conducted by peer educators and the development of educational resources. Where the development of resources is the main activity, the process is considered to be more important than the product.

Kerger (1997) comments that there is no formula for doing such educational work and it is not as simple as merely employing peers. Peer educators have to develop their own methods to impart information, and the methods employed have to be varied according to individual needs, as they are not necessarily able to be replicated across populations, areas, cultures or issues. Kerger insists that one-to-one sessions are the best method, and the subject matter of hepatitis C prevention education needs to be individually determined because generalised messages are confusing. He also argues that individual users have unique needs and their questions require specific answers.

2.5.3 Counselling as education

The one-to-one education provided to users by peer educators as Kerger (1997; 1998) describes would seem to be referred to interchangeably as ‘counselling’. Although the exact methods employed are not detailed, these interventions are not so much the assisting and guiding methods of trauma or relationship counselling, for example, but use a more corrective, advisory or didactic approach. For example, Choi et al. (1996), in their study of 24,335 opiate drug users attending a methadone clinic, found that, after counselling, the majority of current needle sharers (58.3% in 1990; 81.3% in 1995) reported having stopped sharing two weeks after the session. However, Coleman and Ford (1996) argue that immediate post-test data collections, such as that employed by Choi et al., are not good measures of behavioural change, because they simply ascertain short-term alterations in knowledge, beliefs and intentions.

A proposed study of counselling methods may be informative in this regard. Crofts, Aitken and Meade’s study (forthcoming) on a pilot peer-based hepatitis C testing and counselling service at a NSP could be defined as one-to-one education or educational counselling. The three different styles of peer counselling will utilise and evaluate a combination of different pedagogical techniques:

1. the traditional imparting of knowledge from the counsellor/educator (the knower) to the client/student (the recipient of knowledge);
2. an interactive, self-discovery, personalised model of knowledge discovery;
3. a combination of methods including the use of audio-visual material.
2.5.4 Hepatitis C risk assessment and peer education project

The Hepatitis C Risk Assessment and Peer Education Project, conducted by the Tasmanian Users Health and Support league (TUHSL), provided peer education to eighty participating users in a discussion format that included the handing-out of free resources containing safer injecting guidelines, posters, information and tourniquets (Clarke 1998). Each participant was paid an amount of $20. A pre-test/post-test evaluation of the content of the educational sessions showed there was an effective increase in participants’ knowledge as a result of the education provision.

Although it was not made clear at what stage it was administered, the project used a specific adaptation of the Blood Borne Virus Transmission Risk Assessment Questionnaire (BBV TRAQ) project of Turning Point Drug and Alcohol Centre (Melbourne) to find out about injecting practices, risk behaviours and hepatitis C in the Hobart and Glenorchy areas of Tasmania. They found that, although peer education was effective in increasing knowledge about hepatitis C transmission, having such knowledge did not translate into the participants’ engaging in safer behaviours. In fact, seventy-nine out of the eighty participants subsequently engaged in behaviours that placed them at risk of hepatitis C infection. The community-based researchers concluded that ‘other factors cause people to engage in risky behaviours when blood may be around (but not necessarily visible)’ (Clarke 1998:9).

2.5.5 Evaluating the content of hepatitis C educational materials—Swap Cards

Swap cards carrying safer-using messages for hepatitis C (among other things) included in Fitpacks in Sydney’s western suburbs have been shown to be successful in terms of raising awareness, increasing knowledge and providing opportunities for people to discuss their drug-related concerns (Mundy & Wood 1997). An evaluation of their usage showed that 68% of those surveyed kept their cards, 24% passed them on, while only 8% reported throwing them away. The effects of the cards were reported to be enhanced ‘when combined with a strong outreach presence’ (p. 20), but the details of what is meant by this or exactly how the effects were measured are omitted. Despite the apparent success of the swap card program, the cost of reproducing the thirty-two card sets has proven to be the main barrier to continuation (personal communication, G. Stannard 1999). As well, the information contained on the cards needs constant revision and updating.

2.5.6 Evaluating equipment provision

While the hepatitis C prevention activities outlined above are based around specific activities and/or specific target groups, information and education to users also occurs in the context of fixed and outreach NSP. Although education to change norms of behaviour is seen as crucial, it is incomplete alone as a prevention strategy because
education needs to be accompanied by prevention materials in order to accomplish harm reduction. With little or no public education on hepatitis C, the very availability of prevention materials such as clean equipment is of itself educative (Loxley 1997).

The exact nature of the educational component of the equipment provision moments at NSP, however, is not known as these have not been well documented. Despite this, a study of the information needs of clients attending Sydney’s Kirketon Road Centre showed that 67% gained information about hepatitis C and other IDU issues by talking to NSP staff and preferred this method of information provision (Donald 1997). However, as most users in other States and Territories do not get their equipment from NSP’s, other injecting equipment outlets such as pharmacies are also key sites of potential prevention education (Loxley 1998).

In their evaluation study of ‘The Steribox’, Rioufol et al. (1996) reported the program to be successful in reducing the sharing behaviours of users. ‘The Steribox’ consisted of a pack of sterile injecting equipment sold throughout France at a reduced cost through pharmacies, containing needles, filters and sterile water vials, as well as printed matter and the number of toll-free information hot-lines. The researchers attributed the success of the program to the reduced cost of the kit, which was subsidised by the state and sold at a recommended price of five French francs (or approx. AU$1.25). They argued that the kit promotes the sterile use of injection equipment and encourages the reduction of sharing and re-using. The researchers see the pharmacist as strategically positioned to educate, being often the drug user’s first contact with a health professional at a stage of high risk.

Similarly, the researchers who undertook the ‘Fitpack Study’ in Western Australia suggest that pharmacists were reaching injectors who have little or no contact with drug treatment agencies. Although the report commended pharmacists on the contribution they were making in prevention of BBV, the survey respondents did report that, of 34.7% who had problems acquiring the Fitpacks, 64.1% reported problems with the negative attitude of pharmacy staff (Lenton & Quigley-Tan 1997). Loxley (1998) recommends working with pharmacy staff to develop more ‘user friendly’ injecting equipment sales programs.

2.6 Summary of findings from the literature review

It is clear that the literature does not have a lot to offer those interested in the intricacies of HCV/IDU prevention education. Its concerns are largely focused on non-educational aspects of the hepatitis C epidemic. It is clearly recognised, however, that prevention education is challenged by the task of how to convey a complex message about an illicit activity to a diverse and often inaccessible population. Harm minimisation remains the predominant framework although it appears no longer to have its original meaning, therefore giving rise to additional frameworks such as NIROA, the de-regulation of syringes, as well as a redefined emphasis on abstinence-oriented approaches. These policy issues will have considerable impact on HCV/IDU prevention approaches in the immediate and medium term.
There is a strong emphasis in the literature on peer education, although the notion of ‘peer’ is rarely explored other than in relation to using, and there is little discussion of what peer education actually is or does that distinguishes it from other approaches. It is, however, clearly regarded as effective and central to any health-related education for users. There is a recognition of the need to employ other educational resources, and a role for professional health educators is clearly established. In addition, pharmacists have been identified as one group of health professionals which the literature notes as important but underutilised. Finally, NSP by its very existence is an important educational tool over and above its clear primary prevention purpose. However, other educational activities accompanying equipment provision are not well documented.

There is also little evaluation in the literature of the educational underpinnings of various programs or activities. There are not substantive studies of HCV/IDU educators *qua* educators, and the single significant educational issue discussed is the insoluble debate on the relation between information provision, knowledge acquisition and behaviour change. There is also little research investigating the educators themselves and their interests in health education and in IDU issues. This lack of educational research and debate suggests the importance of developing the sector’s capacities in HCV/IDU prevention education through new research initiatives.
3 Initial Consultations

3.1 Introduction

A series of visits to HCV/IDU agencies was undertaken by research staff over the first three months of the project as part of the initial consultation process. These consultations were performed as a ‘rapid assessment process’, i.e. they were undertaken primarily to map the ‘territory’ of HCV/IDU prevention education in Australia, and to identify and enumerate the number of agencies who might be eligible to participate in the survey. We were also seeking potential agency partners for both the key stakeholder interviews and the action research.

The initial consultations, whether conducted via telephone or face-to-face, involved working through a list of ‘mapping’ or rapid assessment questions. The questions were not always asked sequentially and some are clearly neither appropriate nor relevant to all agencies on the consultation list. Nevertheless, the answers provided rich material which greatly assisted in the design and delivery of the survey, in compiling a list of potential informants for the key stakeholder interviews, and in the selection of the action-research sites. Resources and publications collected during these consultations were also helpful in providing the project with a sense of the dominant concerns, focuses and modes used in HCV/IDU prevention education programs.

We were also aware that some agencies also undertake educational activities for people with hepatitis C as well as prevention education. Therefore, for the purposes of the initial consultations, we collected information about any HCV-related education. This turned out to be a wise decision and will be discussed later in this report. It is important to remember, however, that the brief of this project was HCV prevention education for users, not the broader health education agenda for all people with, or affected by, hepatitis C. No matter how often we clarified these parameters, the frequency with which the issues were joined together by many working in the sector, thereby misunderstanding this project’s brief, suggests a real need for similar work to be undertaken in relation to health education to support those educators of people with hepatitis C, particularly in the Hepatitis C Councils.

Key issues covered in these national consultations were:

- What is the extent of the HCV epidemic in your area?
- What is drug-injecting culture like in your area? Are there age, gender, ethnicity, class biases, etc?
HCV/IDU Prevention Education in Australia

- Who is doing HCV education? Is it undertaken in conjunction with other forms of education (e.g. HIV prevention)?

- What HCV project(s) does your organisation conduct?

- What are the constraints affecting HCV education delivery—legal/economic/political/organisational?

- How much staff time is allocated to HCV education? How many volunteers are involved in HCV education delivery?

- What experience does your organisation require of its HCV educators? Qualifications? How do you go about staff recruitment?

- How is the program or project funded?

- What is your relationship like with other agencies delivering HCV education? Do you work directly together in any areas?

- To what extent does your program or project base itself on a NSP?

- What do you see as the key gaps in the delivery of current HCV education?

- What do you understand as ‘peer education’?

- Who is the key contact person in the agency to contact for the survey?

In all, seventy-five people in thirty-six agencies were involved in the initial consultations in all States and Territories, and the full staffs of four agencies were also consulted.

### 3.2 Issues arising from the consultations

#### 3.2.1 Defining education

In emphasising the project’s focus on HCV prevention education for users, initial discussions often required stressing the issues the project was not addressing. This is partly a function of the HCV epidemic itself, as it is already known that many users are HCV positive. One consequence of this is that, in many places, the emphasis in hepatitis C education is directed more at health maintenance and monitoring for people with hepatitis C than at prevention activities. Indeed, several respondents in the consultation seriously questioned whether HCV was now preventable, given such high rates of infection.

While there was some support for including information on NIROA, along the lines argued at the Hobart International Harm Reduction Conference four years ago (Wodak 1997), there seems to be a growing recognition of a ‘feel for steel’ argument. This notion recognises something more in the act of injection than just a drug’s particular effects in that the act of injection has its own unique attractions. As one respondent noted in relation to the proposed
withdrawal of methadone injecting equipment in New South Wales, ‘Needle fixation is alive and well’.

In other domains, most notably the alcohol and other drugs sector, it was evident that HCV/IDU prevention education entailed placing emphasis more on the general provision of information than on direct prevention intervention strategies deliberately targeting users. But even for those groups most often interacting with users—user groups and NSPs—many reported that their only opportunities to talk about hepatitis C came when clients asked questions themselves, which invariably were about treatment for hepatitis C.

Unlike HIV/AIDS educators, it was seen as very difficult for HCV and/or IDU educators to delegate or defer these treatment questions to more medically-oriented personnel. Hence, IDU educators need to be informed about the ‘wall of treatment information’ (as one educator described it), as well as being aware of the latest community development and peer education discourses. This medical and other health knowledge/information must also be continually updated. The conundrum here is that clinical and/or biomedical knowledges become more important and highly regarded forms of knowledge in these circumstances—an example of what was frequently referred to as the ‘re-medicalisation’ of IDU issues.

It is also evident that many IDU educators, whether willingly or not, are obliged to provide education for health professionals increasingly with other agencies. This was noticeable in the number of general practitioner (GP) training sessions that IDU educators reported participating, where again the emphasis was more on treatment and monitoring of the disease than on prevention efforts. Even so, it was noted that the education of health care workers generally happens in an ad hoc manner, and that education for health professionals in hepatitis C rarely reflected concerns related to users.

### 3.2.2 Mapping the ‘sector’

In conjunction with key stakeholders, including AIWL, State and Commonwealth health departments, State-based user groups and other researchers, the project team compiled a list of key sector contacts in each State and Territory. From the outset, it was a difficult task identifying who the key players might be, as HCV/IDU prevention education was our focus and there is no central sector registry or coordinating authority.

It proved very difficult to map any definite or single sector. A range of health institutions provide education relevant to users, but, as it turned out, only the State-based user groups and the NSPs focus specifically on the educational needs of users in relation to hepatitis C. It is interesting to note when it comes to HCV/IDU prevention education, that some of the more prominent alcohol and other drug treatment researchers are not automatically key players.

### 3.2.3 The ‘muddy’ infrastructure

The initial consultations revealed a complex system of HCV/IDU prevention education. Much of this work occurs in conjunction with other forms of prevention (e.g. HIV prevention), and the general perception was that little funding allocated to hepatitis C education was specifically directed at users. An example of the predicament in this area was the role of
Hepatitis C Councils, which varies from State to State: for example, in Western Australia they work closely in conjunction with Western Australian Substance Users Association (WASUA) to provide education to users; whereas, in the Northern Territory the major hepatitis C support network sought to distance itself from users and using.

Similarly, AIDS Councils’ roles varied, though the marginal presence of users in these organisations has meant that hepatitis C education has not attained a high profile. Others pointed out that, especially in New South Wales, the more specialist the IDU organisations, the more likely other agencies expect them to take the running on HCV/IDU issues. Even user-friendly staff in a ‘merged’ organisation like the Tasmanian Council on AIDS and Related Diseases (TASCARD) reported that, for example, users accessing that service were likely to be referred immediately to the NSP worker.

### 3.2.4 Education in the midst of an epidemic

Our focus on prevention education generated a response from many IDU educators that preventing HCV infection among users was a battle already lost. For those who did discuss HCV prevention, their main concern lay in devising strategies to work with initiates to injecting drug use. Users were consistently described as a population notoriously difficult to access, and this is particularly so with young initiates. Despite a shared and growing urgency to target initiates, we found, with the odd exception, only a few agencies which reported that they had managed to do so effectively.

Others spoke of the problems of conducting HCV prevention in a health promotion framework, when the disease was not considered life-threatening. For IDU educators, it was more important to deal with users’ life context and their immediate health needs than focus their attention on HCV prevention. HCV prevention education among users was regarded as rarely effective when conducted in isolation from broader IDU issues.

### 3.2.5 Regional differences

Many respondents attested to the difficulties of cooperating on a nation-wide basis because of regional differences. This was thought to be in large part due to particular ‘using cultures’. For example, the Northern Territory and far north Queensland were characterised by an extensive morphine-using IDU scene, while Sydney was reported to be struggling with an enormous influx of street-based cocaine use. It was reported, however, that a national approach to educational issues was also affected by different State and Territory Governments’ policy decisions, such as the New South Wales decision not to allow wide-bore syringes and winged infusion sets to be supplied to, and distributed from, its NSPs. The different legal environments were also noted (see below).

Finally, even within a State or Territory, there were significant differences, e.g. Tasmania has users peculiar to certain towns or regions. Elsewhere, it was reported that the rural/urban divide is particularly noticeable in relation to the provision of appropriate health services for users, leading to increased pressure being placed on local pharmacies and/or community health centres to provide adequate resources.
3.2.6  Constraints affecting HCV education delivery

Legal

The fact that IDU remains illegal was widely regarded as limiting the scope of HCV/IDU prevention education approaches and hindering the ability of educators to gain access to ‘hard-to-reach’ populations of users. The issue of law reform drew mixed responses, however. On the one hand, there were various respondents determined to pursue drug law reform issues; on the other hand, others regarded such activists as incorrectly seeing law reform as the main game instead of focusing on other more pressing needs.

Economic

Some respondents argued that, in the tight fiscal climate, it was easier to argue for funding large treatment agencies, which were thought to assure regular, sustained contact with users, rather than IDU advocacy groups, which may only at best be directly contacting users fleetingly through their NSPs.

Political

Many respondents were greatly concerned about a perceived decline in commitment to harm reduction philosophies among sector leaders and in government. A second political issue concerned the growing need to deliver ‘BBV awareness’ messages in the secondary schools education system, but many reported constraints in State education departments, particularly in the inability to conduct hepatitis C prevention education in schools and openly refer to the major means of prevention (i.e. NSP).

Ethnocultural

Particular respondents also nominated the issue of stigma in relation to users among Indigenous Australians and in some CALDB communities. It was reported that there were few indigenous workers employed in NSPs and user groups, because of the immediate association with drug-use this might imply. Indigenous workers at one user group reported difficulties in working with fellow workers in the alcohol and other drugs field when the latter mostly adopt an abstinence-based approach.

A second issue emerged in relation to the cultural appropriateness of many HCV/IDU educational materials in content and form, particularly for CALDB clients. There were problems noted with appropriate translations and a reliance primarily on written materials. Some argued that there was an overemphasis on Indochinese users (however, there were programs that did attempt to incorporate other CALDB groups as well). There was also some difficulty in finding IDU educators who were aware of broader cultural issues in relation to Indigenous Australians.

Organisational

Most IDU organisations reported experiencing difficulties with a high rate of educator turnover. Many also reported management instability as a constant and nation-wide problem. As a consequence, many IDU educators reported carrying an unreasonable management load
that interfered with their main task of educating. Other organisational issues were: developing the capacity to produce resources for the training and skilling of management committees; insufficient staff to coordinate the activities of volunteers; stress on workers, especially when dealing with difficult clients; and the stress on peer educators who may have to confront their own drug-using histories. Finally, the issue of professionalism was raised. Staff professionalism was regarded as increasingly valued in user groups and NSPs, yet respondents noted a paucity of adequate training programs. Instead, they still primarily rely on the personal experiences of HCV/IDU educators.

**Funding**

Funding arrangements are also significantly different across Australia. Queensland, for instance, has provided specific hepatitis C funding for five years and has drawn a range of community-based agencies into the provision of education. This has not necessarily happened in other States and Territories. However, even if such specified funding requires service providers to address IDU, the logistics and problems in doing so have not been sufficiently addressed—problems of practice remain. Some of those consulted expressed frustration that there was insufficient time to prepare adequate applications for this sort of specific funding. In some places, intermittent State-based funding opportunities were also often overlooked and/or under-publicised. It is interesting to note that there was a reasonably poor awareness of the range of funding programs to address drug use, particularly in relation to the National Illicit Drug Strategy.

A second issue concerned the merits of cost recovery, which were being cautiously assessed by IDU educators working in NSPs. There is a considerable degree of support for users who can afford to do so paying for some injecting equipment (e.g. water, butterflies), but there is an accompanying worry that there is danger in moving toward full cost recovery.

**Resources**

Many of those consulted complained about the lack of useful resources to address specific groups of users. This was particularly the case in relation to women who inject drugs. A second issue was that even though NSP is a primary function of most IDU organisations, and a lot of HCV prevention occurs in and around the NSP through direct client contact and information in Fitpacks, there was a need to develop discrete written information, photocopies, and other resources for users to access at NSPs.

**3.2.7 Models of education**

Overwhelmingly, the key concepts spoken about were peer education and, to a lesser extent, community development—a notion and concept remarkable by its absence in the literature reviewed for this project. This has entailed a lot of investment in the term ‘community’ without ever explicitly stating who or what the user community is. There is considerable support among the user groups for the TRIBES-based approach to accessing users, i.e. utilising subcultural networks, rather than an approach that focuses merely on injecting behaviour itself. However, there is little penetration of this model beyond user groups, revealing more about the lack of means to disseminate good ideas for IDU education rather than suggesting any shortcomings in the TRIBES program itself.
In assessing the value of peer education, many spoke, first, of the relative advantages of employing current users in preference to ex-users (an issue more fully explored in the in-depth interviews). A second concern was whether paid workers facilitate peer education or can be/remain peers. In the first instance, being a current/recent user was regarded as fundamental. In the second instance, educators’ drug-using was less important than their professionally acquired skills. Issues of trust were also regarded as central to establishing an effective educational relationship. Although peer education was frequently cited as the most effective mode of education and prevention for users, the common traits of a good educator more often referred to were an ability to communicate clearly and to possess good listening skills, a sense of humour and, almost universally, an ability to say ‘I don’t know’.

In commenting on modes of delivery for education, respondents reported that ‘outreach’ was becoming increasingly cost-intensive and yet this mode was rapidly expanding in Sydney and Melbourne, in part because it readily reaches populations not using fixed NSPs. NSPs around Australia were also establishing procedures to extend client/educator interactions. While one NSP manager stated ‘The most important thing is to develop a relationship with clients’, others argued that it was increasingly difficult to engage in one-to-one interactions when client demand is so high at NSPs: ‘We’re just a human vending machine’. Related to this issue was the point some respondents noted, that many educators did not recognise how good pre- and post-test counselling affects delivery of HCV/IDU education and that there are educational opportunities in these counselling moments.

It was reported that pharmacies played varied roles across the States. For example, Western Australia, with only three NSPs, relies heavily on pharmacies handing out Fitpacks. It was estimated that two-thirds of the total needles and syringes were distributed through pharmacies in that State (the figure was 85% in South Australia).

User group magazines and newsletters were almost unanimously regarded as crucial disseminators of information and education. (It was noted, for instance, that NUAA’s *Users News* has a print run thirty times greater than the *National AIDS Bulletin*.) However, it was also reported that there has been no formal evaluation that can conclusively demonstrate the effectiveness of these media.

The central educational dilemma concerned the more complex hepatitis C prevention message that now has to be delivered. This requires a clear shift from cleaning injecting equipment safely to ‘blood awareness’ messages and the need to use new injecting equipment every time, if possible, and not sharing any injecting equipment, again if possible. This shift is welcomed by some educators as there was no unanimously held belief that bleaching messages and the like could be uniformly implemented. Respondents also noted the value in the ‘blood awareness’ idea of a message that focuses less on disease.

### 3.2.8 Understanding injecting cultures

There were three issues raised in relation to changes in injecting cultures. First, educators argued that in the last few years there had been a significant shift from a primarily home-based using scene to more street-based using, especially in the capital cities. This exacerbated difficulties in accessing users, particularly in identifying peer leaders. This problem was more noticeable in areas with mobile population movements, e.g. on Queensland’s Gold Coast.
where many people who attend the NSP at the Gold Coast AIDS Association and Injectors Newsline (GAIN) are transient and it is very difficult to do any follow-up with them. The street scene itself is notoriously unstable. Respondents reported that this was especially noticeable in Canberra, where an increased police presence around one well-known dealing spot simply shifted the activity to another site. Importantly, it was reported that in Melbourne though scenes shift, they leave behind a residual market, creating an additional educational problem.

Second, a proliferating injecting subculture, which remains relatively unexamined in relation to users, is steroid use. Some new research on this population is being conducted in Melbourne. The main educational issue entailed in this pattern of drug injection was reported as being dependent on trying to overcome stereotypes—‘only junkies get Hep C and HIV’.

Third, some respondents argued that since the introduction of large-scale organised crime there have been many changes in the way people use and deal drugs. Trust between the parties involved is no longer there and anxiety levels among many users are higher than they used to be. The ‘scene’ is more volatile as a result. Some argued that before the emergence of organised crime there was a definite camaraderie among users, even where there were poly-drug use and chaotic lifestyles. This point of view was reinforced in the idea that HCV/IDU prevention education must contend with generational differences among users. Respondents reported that there is often disdain and contempt for older ‘career junkies’ expressed by young users, and older users often see younger users as incapable, vulnerable and able to be led easily.

3.2.9 Other HCV versus IDU tensions

Some of the more experienced persons consulted believed that the emergence of hepatitis C and its association with IDU had ‘remedicalised’ IDU education and was eroding the momentum built up by harm reduction approaches and HIV education. It was argued by some that perhaps the most relevant effect of this trend has been the emergence of educators, working in either the public or community sectors, who are required to develop very few preventive approaches among users and, instead, have largely concentrated on providing secondary prevention information to people with hepatitis C and general community education. The dilemma is more than merely semantic, because it shifts the focus back to the disease (hepatitis C) rather than the target group (injecting drug users). It was also argued that more subtle remedicalisation is occurring through the expansion of treatment services, and in particular the enhanced advocacy of abstinence-based approaches to ‘treating’ users.

3.2.10 HCV education in correctional services

Many respondents noted that correctional facilities are very important sites for education (e.g. over 85% of New South Wales inmates are imprisoned for drug-related offences), but also that there are many administrative barriers to overcome in all jurisdictions to implement adequate HCV/IDU prevention activities. BBV education was successfully under way in Western Australia, triggered by a ‘duty of care’ case. However, educators there were still not allowed to address the issue of safer injecting practices. This is yet another example of the recurring message about policy constraints on effecting good quality prevention in a number of settings.
3.2.11 IDU discrimination

NSPs and user groups continue to report widespread discriminatory attitudes among the general public toward IDU. A commonly cited example was the community response to unsafe disposal of needles and syringes. It was argued that, in the majority of cases, the problem of unsafe disposal has been exaggerated by the media. Within the sector, many IDU educators reported an ongoing lack of interest in, and sometimes antipathy for, users among gay and/or HIV services. It was noted that very few sessions, for example, were devoted to IDU issues at the 1998 gay/HIV educators conference in Sydney.

There was a related issue—the stigma associated with drug injection itself. Respondents reported that many users did not want to be identified as ‘junkies’. Also, others attributed poor treatment from health services for hepatitis C positive people to the association with IDU. As one respondent commented, ‘It’s okay to be HIV positive or gay, but still not okay to be a user’.

3.2.12 Centrality of needle and syringe programs

Responding in particular to questions about the constant fear of funding cuts, virtually all those consulted emphasised the fundamental role of NSP and its centrality in the provision of education for users. This was exemplified in the success of NSPs in busy using areas, which offer a range of education and prevention activities beyond equipment provision. At the same time, several educators from both NSPs and other agencies believed that NSPs remain an underutilised resource.

3.2.13 Using social research

Very few hepatitis C education programs or projects had incorporated social research techniques or data into their activities and curriculums, although most were eager to see more useful research conducted, particularly in their own districts. Many of the NSPs visited that had participated in the periodic national finger-prick surveys displayed their results prominently in the centres and regarded this as useful educationally. However, time and resources to use or do social research were seen as luxuries for many services struggling to maintain their existence.

3.3 Conclusions

Apart from achieving the broad mapping of issues to be explored by other methods in the project, two things were striking from these initial consultations. The first was the confirmation of many general themes emerging in the literature concerning IDU and the difficulties of educating users. The second—and more compelling—was the reference to what might be termed ‘structural’ issues and pressures. In the latter, there is a strong message coming from the sector of having to work in a difficult arena while constrained severely by politics, funding shortages, a growing problem to deal with, and a significant lack of expertise to utilise beyond the resources immediately to hand. There was a high degree of unease behind these concerns, and they emerged more keenly in the key stakeholder interviews. Also,
the effects of these structural constraints were revealed in the action research component as markedly affecting educators’ performance and perceptions of their ultimate effectiveness.

As a result, a great deal is riding on current initiatives, such as the new AIVL national education project, and even this research project. There is a strong sense of urgency and a certain degree of uncertainty abroad. It is all the more impressive, then, to realise just exactly what these HCV/IDU educators are achieving in these circumstances, as the survey discovered. We now turn to the findings of that survey.
4

Survey Results

4.1 The survey

In order to map the HCV/IDU prevention education that was currently occurring in Australia, a nation-wide survey was conducted. In the first part of the survey, agencies within which such education was being conducted were first asked a series of questions about the agency itself in an ‘Agency Questionnaire’. Then each agency was asked to describe its HCV/IDU prevention education activities in a second ‘Activity Questionnaire’, completing one questionnaire for each activity they were doing. As a consequence an agency completed only one ‘Agency Questionnaire’ but could complete a number of ‘Activity Questionnaires’ describing each activity in turn. It is important to note that the ‘respondents’ to this survey were not the people filling them in as such, but, in the first instance the agencies and in the second their educational activities.

The questionnaires were piloted on three agencies, which each completed the Agency Questionnaire and returned a total of eight completed Activity Questionnaires. One of these Activity Questionnaires was discarded because it related to an educational activity for service providers rather than users, and the questionnaire’s instructions subsequently altered to clarify its purpose. Both Agency and Activity Questionnaires were slightly revised in the light of the pilot study and sent out to all identified agencies.

4.1.1 The Agency Questionnaire

The Agency Questionnaire comprised a combination of open-ended and forced-choice questions. Questions were included on the following:

Section A: Agency information

- name, location, contact details;
- agency type;
- the general nature of all the services delivered, non HCV/IDU services delivered;
- the funding arrangements—total budget (to get a sense of the size of the organisation);
- staffing numbers—general.
Section B: HCV/IDU prevention education in the agency

• list names of all HCV/IDU activities;
• type of activities;
• HCV/IDU staffing;
• HCV/IDU funding.

Section C: Organisational structure and policy

• organisational aims;
• community served;
• governance;
• political context;
• cost recovery;
• health education model;
• legal contexts.

4.1.2 The Activity Questionnaire

The Activity Questionnaire comprised mainly forced-choice and closed-ended questions, with some open-ended questions. It asked about the following:

• name of host agency, name and postcode location of the activity;
• the people—target populations to whom the HCV prevention education activity was targeted;
• the educational content, objectives and philosophy of the activity;
• the mode of delivery;
• the educational materials used and resources produced;
• the funding sources, level of funding and relative contribution (if more than one funding body);
• cost (per year) to run and level of ‘cost recovery’ (if any);
• evaluation—what works and how do you know it does;
• the measures of success;
• sustainability and duration;
• how to improve the effectiveness/quality/success of the HCV/IDU activity.

4.1.3 The sample

The purpose of this part of the project was to survey the population of agencies in Australia delivering direct HCV/IDU prevention education. The list of organisations to be approached had to be compiled through a process of consultation and inquiry, as no such list had previously existed. In all, 195 agencies were identified as potential respondents to the agency survey, although it was known that there was considerable overlap in this list where nominated programs were nested within larger agencies. In such cases requests to participate were sent to both. Also, many agencies offered only a slim chance of being involved in HCV/IDU prevention education, e.g. PLWHA organisations. However, these were included anyway and the initial mail-out was as wide and inclusive as possible just in case. We expected that a fair number of agencies
would either return blank questionnaires as they were undertaking no HCV/IDU prevention education, or simply not respond, or send the survey around within the organisation to an appropriate program (which was likely to have received one already). In all sixty-eight agencies replied.

The Agency Questionnaire as posted to: user groups; primary NSPs; AIDS Councils; PLWHA organisations; regional health services; haemophilia organisations; correctional services (including juvenile justice departments); drug and alcohol agencies; Hepatitis C Councils; and sex worker groups. Several (from three to ten) Activity Questionnaires accompanied each Agency Questionnaire. The numbers sent out were allocated according to relative size and the anticipated number of HCV/IDU prevention activities gleaned from the initial consultations. The sixty-eight agencies returned a total of 118 ‘Activity Questionnaires’.

### 4.2 Agency Questionnaire

#### 4.2.1 Agency - sample characteristics

Sixty-eight agencies responded to the survey with each sector providing hepatitis C education in Australia represented. The breakdown of respondents by agency type is shown below in Table 1.

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Exchange</td>
<td>28</td>
<td>41.2</td>
</tr>
<tr>
<td>HIV/AIDS Public Sector Services</td>
<td>11</td>
<td>16.2</td>
</tr>
<tr>
<td>AOD Services</td>
<td>5</td>
<td>7.4</td>
</tr>
<tr>
<td>User Groups</td>
<td>7</td>
<td>10.3</td>
</tr>
<tr>
<td>Correctional Services</td>
<td>4</td>
<td>5.9</td>
</tr>
<tr>
<td>Hepatitis C Councils</td>
<td>4</td>
<td>5.9</td>
</tr>
<tr>
<td>AIDS Council/PLWHA</td>
<td>3</td>
<td>4.4</td>
</tr>
<tr>
<td>Other (Sex worker, youth, private)</td>
<td>6</td>
<td>8.7</td>
</tr>
</tbody>
</table>

The largest response to the survey (39.7%) came from agencies located in New South Wales. All other Australian States and Territories were represented, with 16.2% of agencies located in Queensland, 13.2% in Victoria, 10.3% in Tasmania, 7.4% in South Australia, 5.9% in the Australian Capital Territory, 4.4% in Western Australia and 2.9% in the Northern Territory. Half (50.7%) of the agencies were State Government organisations, 40.3% were community-based or non-government organisations, and the remaining 9% were Commonwealth Government, Local Government, or other organisations.
A majority of agencies were small, with 45.6% reporting staff numbers to be between one and four people employed on a full-time basis and 48.5% reporting one to four part-time staff. Almost all (98.4%) of participating agencies were themselves involved in direct service delivery.

4.2.2 Agency - funding

Over three-quarters (77.3%) of agencies received all their funding from an external source. The remaining agencies were either fully (12.1%) or partially (10.6%) self-funded. Two agencies (2.9%) did not report their funding arrangements. In a multiple response question, 98.5% of agencies listed State and Territory Government health departments to be a main funding body, and 27.7% of agencies were funded under their State’s AIDS and infectious disease funding. A further 13.8% listed Commonwealth Health as a main source of funding, and 12.3% received at least part of their funding from a wide variety of sources (e.g. religious organisation, drug company, project funding, donations).

4.2.3 Agency - context of hepatitis C education delivery

In order to have some understanding of the context in which hepatitis C education was delivered, the agencies were asked to list the non hepatitis C activities they delivered. It is clear that hepatitis C education takes place within organisations that offer a variety of other services. In a multiple response question, HIV/AIDS information, counselling and testing services (36.2%) and sexual health education and promotion (34.5%) were the most commonly reported services delivered in addition to their hepatitis C related services. Other services most commonly offered by agencies included community health education (24.1%), advocacy (17.2%), research and policy development (17.2%), and drug and alcohol detoxification (15.5%).

4.2.4 Agency - hepatitis C prevention activities

The main focus of hepatitis C prevention activities reported in an open-ended multiple response question was hepatitis C counselling (26.8%), testing and screening services (25.0%), the training of health professionals (30.4%) and health care workers (19.6%), information provision activities (17.9%), and involvement with user groups and/or Hepatitis C Councils (14.3%). Activities involving community education forums, methadone maintenance, and research and policy development were delivered in each case by 10.7% of agencies.

Agencies were asked to describe the general nature of the hepatitis C prevention activities they delivered (Table 2). There were no differences in the types of hepatitis C activities delivered by the various agencies, except that correctional service agencies in the sample did not provide NSP and they were also more likely to provide other methods (e.g. referring users to NSP after release).
Table 2: Types of Hepatitis C Services Delivered

<table>
<thead>
<tr>
<th>Hepatitis C Service</th>
<th>Frequency</th>
<th>Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSP - fixed</td>
<td>49</td>
<td>73.1</td>
</tr>
<tr>
<td>Other (non-HCV/IDU education)</td>
<td>49</td>
<td>73.1</td>
</tr>
<tr>
<td>Peer education</td>
<td>38</td>
<td>56.7</td>
</tr>
<tr>
<td>Drop-in</td>
<td>27</td>
<td>40.3</td>
</tr>
<tr>
<td>NSP - outreach</td>
<td>26</td>
<td>38.8</td>
</tr>
<tr>
<td>Outreach</td>
<td>20</td>
<td>29.9</td>
</tr>
<tr>
<td>Support group</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>Small media</td>
<td>58</td>
<td>86.6</td>
</tr>
<tr>
<td>Newsletter</td>
<td>22</td>
<td>32.8</td>
</tr>
<tr>
<td>Large media</td>
<td>7</td>
<td>10.4</td>
</tr>
<tr>
<td>Assessment and referral</td>
<td>41</td>
<td>61.2</td>
</tr>
<tr>
<td>Advocacy and users rights</td>
<td>35</td>
<td>52.2</td>
</tr>
<tr>
<td>Community development</td>
<td>34</td>
<td>50.7</td>
</tr>
<tr>
<td>Other</td>
<td>9</td>
<td>13.4</td>
</tr>
</tbody>
</table>

*Multiple responses given

The numbers of agency staff involved in HCV/IDU prevention education are shown below in Table 3. Just under one-quarter (22.4%) had no full-time staff, 31.3% had one staff member, 19.4% had two, and only 27% had more than three full-time staff engaged in HCV/IDU prevention education.

Table 3: Agency Staffing Levels in HCV/IDU Education

<table>
<thead>
<tr>
<th>HCV Staffing</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Full time (n=67)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>15</td>
<td>22.4</td>
</tr>
<tr>
<td>1</td>
<td>21</td>
<td>31.3</td>
</tr>
<tr>
<td>2</td>
<td>13</td>
<td>19.4</td>
</tr>
<tr>
<td>3-5</td>
<td>9</td>
<td>13.5</td>
</tr>
<tr>
<td>6+</td>
<td>9</td>
<td>13.5</td>
</tr>
<tr>
<td><strong>Part time (n=67)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>23</td>
<td>34.3</td>
</tr>
<tr>
<td>1</td>
<td>17</td>
<td>25.4</td>
</tr>
<tr>
<td>2-4</td>
<td>19</td>
<td>28.3</td>
</tr>
<tr>
<td>5+</td>
<td>8</td>
<td>12.0</td>
</tr>
</tbody>
</table>
4.2.5 Agency - organisational structure and policy

Clientele

In an open-ended question, agencies were asked to describe the specific community/ies with which they worked. Multiple responses were given to this question and agencies listed a variety of target groups to whom they delivered services. Over two-thirds (68.2%) of agencies reported that they worked with users and 56.1% of agencies worked with young people. Other target communities included homosexually active people (39.4%), the general community (30.3%), Indigenous Australians (22.7%), sex workers (18.2%), CALDB/refugees (16.7%), and homeless people and prisoners (both 15.2%).

Governance

Agencies were asked whether they had a board, reference or consumer group to support their HCV/IDU prevention activities. Less than half (40.9%) of the agencies had set up a board, committee or other group to support their HCV/IDU prevention activities and, while 19.7% of agencies were planning to do this in the near future, 39.4% did not have a governing committee. Only one third (33.3%) of agencies had user participation on their board, committee or governing body. User groups in the sample were more likely to have user participation on their boards whereas AOD agencies were not. All user groups claimed some user participation whereas no AOD agencies did.

Cost recovery

While a majority of agencies did not have a policy of cost recovery, and only one agency had total cost recovery, 27.7% of agencies were involved in partial cost recovery, and 4.6% (3) were planning to implement cost recovery in the near future. Of those agencies involved in cost recovery, 61.9% were recovering costs on their NSP, 57.1% were charging for training and education, and 33.3% for resources/educational materials (multiple responses given).
4.3 Activity Questionnaire

In total, 118 Activity Questionnaires reporting on HCV/IDU prevention activities were completed. The breakdown of returned questionnaires by category of auspicing agency is shown below in Table 4. The largest numbers of responses came from primary NSPs (29.7%), user groups (22.9%), and HIV/AIDS Regional Health Services (17.8%).

Table 4: HCV/IDU Prevention Education Activity by Agency Type

<table>
<thead>
<tr>
<th>Agency Type</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary NSPs</td>
<td>35</td>
<td>29.7</td>
</tr>
<tr>
<td>User Groups</td>
<td>27</td>
<td>22.93</td>
</tr>
<tr>
<td>HIV/AIDS Regional Health</td>
<td>21</td>
<td>17.8</td>
</tr>
<tr>
<td>Correctional Services</td>
<td>9</td>
<td>7.6</td>
</tr>
<tr>
<td>Alcohol and Other Drugs Services</td>
<td>6</td>
<td>5.1</td>
</tr>
<tr>
<td>Hepatitis C Councils</td>
<td>5</td>
<td>4.2</td>
</tr>
<tr>
<td>Other/Private</td>
<td>5</td>
<td>4.2</td>
</tr>
<tr>
<td>Youth Organisations</td>
<td>5</td>
<td>4.2</td>
</tr>
<tr>
<td>AIDS Councils</td>
<td>4</td>
<td>3.4</td>
</tr>
<tr>
<td>Sex Worker Groups</td>
<td>1</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>118</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Almost half (46.1%) of the questionnaires completed located the HCV/IDU prevention education activity in New South Wales and the Australian Capital Territory, 16.7% in Queensland, 13.7% in Tasmania, 11.8% in Victoria, 5.9% in the Northern Territory, and 2.9% each in Western Australia and South Australia. These figures may not represent all the activity in the smaller States and Territories, but they accurately represent the comparative level of activity according to the questionnaires returned.

4.3.1 Hepatitis C prevention education activities

Agencies were asked to name the HCV/IDU prevention education activity they were reporting. A total of twenty-one types of prevention education activity were identified. The frequency and percentage of each activity type is listed in the Table 5.
Table 5: Types of HCV/IDU Prevention Education Activity

<table>
<thead>
<tr>
<th>Activity Type</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>NSP</td>
<td>27</td>
<td>23.1</td>
</tr>
<tr>
<td>Information distribution</td>
<td>25</td>
<td>21.4</td>
</tr>
<tr>
<td>Information workshop</td>
<td>6</td>
<td>5.1</td>
</tr>
<tr>
<td>Peer-based educ’n/support</td>
<td>17</td>
<td>14.5</td>
</tr>
<tr>
<td>Worker training</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>One-on-one client educ’n</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Visual displays</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>HCV educ’n resource</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Magazine</td>
<td>4</td>
<td>3.4</td>
</tr>
<tr>
<td>Info/liaison officer</td>
<td>2</td>
<td>1.7</td>
</tr>
<tr>
<td>Educ’n program</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Clinic - HCV/IDU</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td>Phone counselling</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Survey NSP clients</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Infection control program</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Methadone program</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Outreach</td>
<td>11</td>
<td>9.4</td>
</tr>
<tr>
<td>Counselling</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Social activities</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Hep B vaccine program</td>
<td>1</td>
<td>0.9</td>
</tr>
<tr>
<td>Policy dev’t/advocacy</td>
<td>3</td>
<td>2.6</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>*1178</td>
<td>100</td>
</tr>
</tbody>
</table>

* 1 missing case

4.3.2 Target population

Agencies were asked to provide information about the people to whom their activities were targeted. Forty-four percent listed activities that provided information to a known user group or individual users. Over one quarter (29.3%) of HCV/IDU prevention education activities targeted a specific sub-population such as young people or prisoners within which IDU is assumed, and 26.7% of activities provided HCV prevention information to the general population in which IDU is assumed. The majority of HCV/IDU prevention activities were non gender-specific (94.9%) and non age-specific (88.1%), with small numbers of HCV/IDU prevention education activities targeting men only (5.2%) and young people (11.0%). No activities were specifically targeted at women. A number of HCV/IDU prevention education activities were directed specifically to gay or bisexual men (14.8%), lesbian women (11.3%), indigenous people (17.3%), and CALDB populations (16.1%), mainly people of Asian descent (11 cases). Other features of the target populations were assessed in a question that allowed for multiple responses and are listed below in Table 6. Regular users were targeted by the majority of activities (71.6%), with over
half of the activities targeted at people with hepatitis C, recreational users, and homeless or at-risk persons.

Table 6: Target Population of HCV/IDU Prevention Education Activity

<table>
<thead>
<tr>
<th>Group or individual targeted</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regular users</td>
<td>83</td>
<td>71.6</td>
</tr>
<tr>
<td>People with hepatitis C</td>
<td>66</td>
<td>56.9</td>
</tr>
<tr>
<td>Recreational users</td>
<td>65</td>
<td>56.0</td>
</tr>
<tr>
<td>Homeless/at risk</td>
<td>63</td>
<td>54.3</td>
</tr>
<tr>
<td>Non-specific/assumed users</td>
<td>58</td>
<td>50.0</td>
</tr>
<tr>
<td>Sex workers</td>
<td>52</td>
<td>44.8</td>
</tr>
<tr>
<td>PLWHA &amp; hepatitis C</td>
<td>47</td>
<td>40.5</td>
</tr>
<tr>
<td>PLWHA</td>
<td>40</td>
<td>34.5</td>
</tr>
<tr>
<td>Low literacy</td>
<td>39</td>
<td>33.6</td>
</tr>
<tr>
<td>Tattoo/body piercing</td>
<td>38</td>
<td>32.8</td>
</tr>
<tr>
<td>Users in treatment</td>
<td>34</td>
<td>29.3</td>
</tr>
<tr>
<td>People in custodial care</td>
<td>27</td>
<td>23.3</td>
</tr>
</tbody>
</table>

4.3.3 Location

The target populations for the HCV/IDU prevention education activity were spread across urban (39.1%), rural (26.9%), and Statewide locations (26.1%), with 7.8% of activities were non location-specific. One-fifth (20.2%) included a target population in custodial care. Target populations were also located in supported accommodation or refuges (both 16.3%), non-custodial care (10.9%) and detoxification units (9.8%).

4.3.4 Mode of delivery

Almost half of all educational activities are delivered as informal counselling (46.6%). Thirty percent (30.2%) are delivered as face-to-face presentations. Users’ newsletters/magazines accounted for 14.7%, with formal counselling (12.9%) and telephone information/counselling (11.2%) also being used.

4.3.5 Place of delivery

Over a third (37.7%) of the activities take place within a fixed NSP. Nineteen percent (19.3%) are delivered within a group setting, and 16.7% of activities take place in no defined setting. Mobile NSPs (7.9%), outreach (7.9%), drop-in centres (5.3%), and entertainment venues (2.6%) are infrequently used as sites for HCV/IDU prevention education.
4.3.6 Frameworks and emphases

Agencies were asked about the general approach their HCV/IDU prevention education took and provided multiple responses to a series of terms describing common approaches. ‘Harm reduction’ was the most commonly reported (95.7%), then prevention of transmission (81.9%), health promotion (61.2%), self-empowerment (47.4%), sexual health (42.2%), and community development (39.7%). Surveillance/detection and abstinence are rarely used (6.9% and 4.3% respectively).

4.3.7 Peer-based education

When asked whether the HCV/IDU prevention education activities were peer-based, 58.8% reported that they were. Only one quarter (24.1%) involved user and/or ex-user peer-based educators. Having educators from the same social grouping as that being targeted, such as young people or gay men, was infrequently reported (3.7%).

Table 7: Educator Characteristics (n=108 with 10 missing cases)

<table>
<thead>
<tr>
<th>Type of Educator</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>User</td>
<td>19</td>
<td>17.6</td>
</tr>
<tr>
<td>Ex-user</td>
<td>7</td>
<td>6.5</td>
</tr>
<tr>
<td>Same social group peer</td>
<td>4</td>
<td>3.7</td>
</tr>
<tr>
<td>User &amp; same social group peer</td>
<td>20</td>
<td>18.5</td>
</tr>
<tr>
<td>Other peer-based</td>
<td>13</td>
<td>12.0</td>
</tr>
<tr>
<td><strong>Subtotal peer-based</strong></td>
<td><strong>55</strong></td>
<td><strong>58.3</strong></td>
</tr>
<tr>
<td>Non peer-based</td>
<td>45</td>
<td>41.7</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>108</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

4.3.8 Educational content

Agencies were asked to indicate the areas of education covered in the HCV/IDU prevention education activity and these are shown in Table 8. Information provision directly related to sharing injecting equipment and HCV transmission and its effects, form the content of the majority of the HCV/IDU prevention education activities. Sexual practices and risk behaviours, drug-related harm reduction, blood awareness and cleaning equipment as well as testing and referral information were also main content areas. Attitudinal and coping skills rated lowest in terms of the content of education delivered.
Table 8: The Content of the HCV/IDU Prevention Education Activity

<table>
<thead>
<tr>
<th>Areas of Education</th>
<th>Frequency</th>
<th>Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sharing needles &amp; equipment</td>
<td>116</td>
<td>98.3</td>
</tr>
<tr>
<td>Modes of hepatitis C transmission</td>
<td>114</td>
<td>96.6</td>
</tr>
<tr>
<td>Hepatitis C &amp; its effects</td>
<td>110</td>
<td>93.2</td>
</tr>
<tr>
<td>Sexual practices/risk behaviours</td>
<td>102</td>
<td>86.4</td>
</tr>
<tr>
<td>Safer injecting technique</td>
<td>100</td>
<td>84.7</td>
</tr>
<tr>
<td>Drug-related harm reduction</td>
<td>97</td>
<td>82.2</td>
</tr>
<tr>
<td>First aid/blood spills &amp; awareness</td>
<td>91</td>
<td>77.1</td>
</tr>
<tr>
<td>Cleaning equipment</td>
<td>90</td>
<td>76.3</td>
</tr>
<tr>
<td>Testing &amp; referral agencies</td>
<td>87</td>
<td>73.7</td>
</tr>
<tr>
<td>Tattooing/body piercing</td>
<td>75</td>
<td>63.6</td>
</tr>
<tr>
<td>Hepatitis C stigma/discrimination</td>
<td>68</td>
<td>57.6</td>
</tr>
<tr>
<td>IDU stigma/discrimination</td>
<td>65</td>
<td>55.1</td>
</tr>
<tr>
<td>Consumer participation/rights</td>
<td>57</td>
<td>48.3</td>
</tr>
<tr>
<td>Social impact of hepatitis C</td>
<td>57</td>
<td>48.3</td>
</tr>
<tr>
<td>Personal &amp; interpersonal skills</td>
<td>40</td>
<td>33.9</td>
</tr>
<tr>
<td>Self-esteem</td>
<td>36</td>
<td>30.5</td>
</tr>
<tr>
<td>Gay stigma/discrimination</td>
<td>33</td>
<td>28.0</td>
</tr>
<tr>
<td>Racial/ethnic stigma/discrimination</td>
<td>30</td>
<td>25.4</td>
</tr>
<tr>
<td>Abstinence</td>
<td>28</td>
<td>23.7</td>
</tr>
<tr>
<td>Peer-group pressure</td>
<td>29</td>
<td>24.6</td>
</tr>
<tr>
<td>Assertiveness</td>
<td>27</td>
<td>22.9</td>
</tr>
<tr>
<td>Relationships counselling</td>
<td>18</td>
<td>15.3</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>14.4</td>
</tr>
</tbody>
</table>

*Multiple responses given

4.3.9 Materials used

Agencies were asked about the production and use of existing materials to assist in the HCV/IDU prevention education activity upon which they were reporting. While only 9.9% produced all of their own materials, 73.0% produced some of the educational materials used. The majority (87.3%) adapted all or some materials used from existing materials. All activities used at least some existing educational materials that had been developed by others. When asked, in an open-ended question, to list the main educational materials that were being used for the HCV/IDU prevention education activity, the majority (90.5%) used small media—pamphlets, fliers or booklets—while both posters and newsletters were popular forms of communication (56.9% each). Videos (31.0%) and service guides and maps (26.7%) were also used. The type of HCV/IDU prevention materials used are shown in Table 9.
Table 9: Types of Educational Materials Used

<table>
<thead>
<tr>
<th>Educational materials</th>
<th>Frequency</th>
<th>Percentage*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written (pamphlets, fliers, booklets)</td>
<td>105</td>
<td>90.5</td>
</tr>
<tr>
<td>Posters</td>
<td>66</td>
<td>56.9</td>
</tr>
<tr>
<td>Community newsletter/magazine</td>
<td>66</td>
<td>56.9</td>
</tr>
<tr>
<td>Video</td>
<td>36</td>
<td>31.0</td>
</tr>
<tr>
<td>Service guides &amp; maps</td>
<td>31</td>
<td>26.7</td>
</tr>
<tr>
<td>Electronic - other (e.g. website)</td>
<td>14</td>
<td>12.1</td>
</tr>
<tr>
<td>Electronic - audio</td>
<td>5</td>
<td>4.3</td>
</tr>
<tr>
<td>Other</td>
<td>17</td>
<td>14.7</td>
</tr>
</tbody>
</table>

*Multiple responses given.

4.3.10 The funding of hepatitis C prevention education activities

Funding bodies

The majority (89.8%) of activities were funded by an external body specifically for hepatitis C prevention education. Twelve activities (10.2%) were unfunded. Local Government provided partial funding for five (4.2%) of the activities, but the majority of the funding for hepatitis C prevention education came either fully (30.9%) or partially (60.3%) from State Governments. The Commonwealth Government funds a small number of activities and so do a range of non-government agencies. In relation to BBV funding, 37.7% of activities are fully and 55.1% are partially funded by combined State/Territory and Commonwealth funds.

Cost

In 63.0% of cases, activities were not costed separately, and of those that were 7.0% cost less than $11,000 per annum, 13.0% cost between $11,000 and $40,000, 9.0% cost $41,000 - $100,000 and (excluding correctional services, but including other public sector agencies) 8.0% over $101,000 but below $250,000 per annum.

Cost recovery

Only 12.8% of HCV/IDU prevention education activities were involved in partial or total cost recovery. In these few cases, ten recovered costs through the sale of NSP resources, four through payment for training, and six through payment for consultancy or other activities.

Sustainability

When asked how long the HCV/IDU prevention education activity has been running, more than half were well established, with almost one third of activities (31.3%) having been running for between two and five years and just over one quarter (26.1%)...
for over five years. Twenty-nine percent (28.7%) of activities had been established for between seven months and two years, and 13.9% of activities were less than six months old.

### 4.3.11 Evaluation of the hepatitis C prevention activity—what works and how do we know it does?

The methods used to evaluate the effectiveness of the HCV/IDU prevention education activities are shown in Table 10. Eighteen percent (18.3%) of activities were not formally evaluated.

In judging the highest priority for ensuring the quality, effectiveness and success of prevention education, respondents rated ‘funding’ the highest. Over a half (54.2%) placed ‘secure funding’ first, second or third out of fifteen possible measures, and 47.1% placed ‘additional funding’ similarly. ‘More staff’ was also considered a priority with 44.0% of respondents, placing it within the top three issues involved in improving prevention education. ‘Collaboration’ was another measure that was considered important to the effectiveness of education with well over a third (43.5%) of cases placing it at least fifth out of fifteen possible measures.

<table>
<thead>
<tr>
<th>Measures</th>
<th>Always</th>
<th>Sometimes</th>
<th>Occasionally</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>People count</td>
<td>57.4</td>
<td>21.3</td>
<td>9.3</td>
<td>12.0</td>
</tr>
<tr>
<td>Participant verbal feedback</td>
<td>58.3</td>
<td>28.7</td>
<td>7.4</td>
<td>5.6</td>
</tr>
<tr>
<td>Informal chats with colleagues</td>
<td>41.0</td>
<td>43.8</td>
<td>13.3</td>
<td>1.9</td>
</tr>
<tr>
<td>Materials count</td>
<td>33.6</td>
<td>38.3</td>
<td>11.2</td>
<td>16.8</td>
</tr>
<tr>
<td>Documenting own practice/own observations</td>
<td>34.7</td>
<td>43.9</td>
<td>11.2</td>
<td>10.2</td>
</tr>
<tr>
<td>Information exchange with other agencies</td>
<td>28.6</td>
<td>45.9</td>
<td>16.3</td>
<td>9.2</td>
</tr>
<tr>
<td>Participant satisfaction survey</td>
<td>28.7</td>
<td>33.3</td>
<td>10.3</td>
<td>27.6</td>
</tr>
<tr>
<td>HCV seroconversion rate</td>
<td>24.5</td>
<td>17.0</td>
<td>9.6</td>
<td>48.9</td>
</tr>
<tr>
<td>Individual participant interviews</td>
<td>21.4</td>
<td>34.7</td>
<td>10.2</td>
<td>33.7</td>
</tr>
<tr>
<td>Receiving feedback on public talks</td>
<td>21.6</td>
<td>35.1</td>
<td>15.5</td>
<td>27.8</td>
</tr>
<tr>
<td>Using other official estimates</td>
<td>13.0</td>
<td>19.6</td>
<td>16.3</td>
<td>51.1</td>
</tr>
<tr>
<td>Pre-test/post-test knowledge survey</td>
<td>16.5</td>
<td>16.5</td>
<td>17.6</td>
<td>49.4</td>
</tr>
<tr>
<td>Focus groups</td>
<td>18.7</td>
<td>26.4</td>
<td>13.2</td>
<td>41.8</td>
</tr>
<tr>
<td>Researching your work as higher educ’n.</td>
<td>1.3</td>
<td>7.8</td>
<td>11.7</td>
<td>79.2</td>
</tr>
<tr>
<td>Other measures</td>
<td>21.7</td>
<td>1.3</td>
<td>0</td>
<td>65.2</td>
</tr>
</tbody>
</table>
The relationship between education activity and evaluation method

There is a large number of education activities occurring in the sector. In part this reflects the range of concerns that educators have to deal with in their day-to-day practice and the particular clientele they target. It also reflects the variety of agencies within the sector and their particular emphases and histories. There is also a large number of evaluation methods being used. This also reflects the variety of agencies in the sector and the emphases of those agencies. It is interesting to examine the way the various agencies specialise in particular education activities and to see if certain evaluation methods are preferred for particular education activities or by particular agencies. The number of variables available to describe both education activities and evaluation methods were too numerous to facilitate a simple description of differences between agencies. Therefore, factor analysis was used to summarise the available data on education activities and evaluation methods and to identify naturally occurring clusters of practice.

The factor analysis of education activities provided four factors which accounted for 53% of the total variance in the twenty-three original items. The factors extracted were: (1) *Hepatitis C Knowledge* (26.2% of variance) which included all items of factual content in relation to the epidemiology and transmission of hepatitis C; (2) *Interpersonal Skills* (11.4% of variance) which included issues to do with personal skills, relationships, peer-group pressure, assertiveness and self-esteem; (3) *Discrimination* (8.1% of variance) which included items that dealt with the social impact of hepatitis C, stigma and discrimination related to HCV and IDU, and other forms of marginalisation; and (4) *Harm Reduction* (7.1% of variance) which included items related to safe injecting, drug-related harm reduction, and consumer participation and rights. The factors *Interpersonal Skills* and *Discrimination* scored negatively and they have been transformed to ensure that higher scores on these factors are associated with higher values in the underlying variables. The emphasis on the provision of basic information about HCV transmission is notable.

In the case of the evaluation methods employed, a principal components analysis identified four factors that accounted for 59% of the total variance in the fourteen items relating to evaluation methods used. The four factors extracted were labelled as: (1) *Formal Methods* (28.3% of the variance) which included the use of focus groups, client satisfaction surveys, verbal feedback, pre-test/post-test knowledge surveys, and individual interviews; (2) *Epidemiological Monitoring* (11.4% of variance) which included reliance on HCV incidence, official estimates, and participants’ own formal research; (3) *Informal Monitoring* (10.1% of variance) which included information exchange with other organisations, informal chats with colleagues, and the participants’ own observations; and (4) *Throughput Monitoring* (8.9% of variance) which involved counts of clients and materials. This factor scored negatively and it has been transformed to ensure that higher scores on this factor are associated with higher values in the underlying variables. Among evaluation methods, the reliance on formal methods is interesting.
Correlations between the extracted factors describing education activities and those describing evaluation methods were examined to determine if there were associations between particular activities and methods (see Table 11). The correlations were generally low with only four of the sixteen statistically significant. *Formal Evaluation* was positively associated with the education activities of *Interpersonal Skills* and *Discrimination* whereas *Epidemiological Monitoring* was positively associated with *HCV Knowledge*. Finally, *Informal Evaluation* was positively associated with education activity of *Discrimination*.

Although statistically significant, the variance accounted for in these four correlations ranged from 4% to just over 10%, indicating that there are not strong relationships between particular education activities and particular evaluation methods. This finding suggests that the evaluation techniques preferred by the sector are not necessarily being chosen because of any defined educational imperative, or that education activities do not readily suggest particular evaluation methods to the agencies delivering those activities. The particular evaluation method chosen often bears only a weak relationship to nature of the education activity it is being asked to evaluate. It may be the motives for evaluation and the methods chosen are derived elsewhere, e.g. funding authority demands, longstanding practice, etc. There is clearly room to match evaluation techniques better to the educational issues at stake in any activity. It is also interesting to note that of the four significant correlations, there were none in relation to *Harm Reduction*, and those factors which might be considered as less central aspects of the HCV/IDU prevention education curriculum, *Interpersonal Skills* and *Discrimination*, were surprisingly more likely to rely on formal techniques of evaluation.

### Table 11: Correlations between Education Activities and Evaluation Methods

<table>
<thead>
<tr>
<th></th>
<th>HCV Knowledge</th>
<th>Interpersonal Skills</th>
<th>Discrimination</th>
<th>Harm Reduction</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Formal Methods</strong></td>
<td>.11 p=.258</td>
<td>.29 p=.002</td>
<td>.21 p=.020</td>
<td>-.13 p=.152</td>
</tr>
<tr>
<td><strong>Epidemiological</strong></td>
<td>.34 p=.000</td>
<td>.03 p=.780</td>
<td>.10 p=.264</td>
<td>.02 p=.853</td>
</tr>
<tr>
<td><strong>Informal Monitoring</strong></td>
<td>.06 p=.558</td>
<td>-.09 p=.316</td>
<td>.20 p=.030</td>
<td>-.02 p=.802</td>
</tr>
<tr>
<td><strong>Throughput</strong></td>
<td>.03 p=.714</td>
<td>-.02 p=.867</td>
<td>.17 p=.073</td>
<td>.09 p=.360</td>
</tr>
</tbody>
</table>

In relation to the issue of whether certain agencies specialised in or preferred certain education activities or evaluation methods, three agencies types were included in the analysis: primary exchanges; public sector agencies (including correctional services and HIV/AIDS regional services); and community organisations (including user groups, hepatitis C councils, HIV/AIDS and PLWHA organisations) (see Table 12).
Table 12: Means of Factor Scores for Education Activities and Evaluation Methods with respect to Agency Type

<table>
<thead>
<tr>
<th></th>
<th>Primary exchange</th>
<th>Public sector agency</th>
<th>Community organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>HCV Knowledge</td>
<td>-.02</td>
<td>.01</td>
<td>.00</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>.14</td>
<td>-.04</td>
<td>-.07</td>
</tr>
<tr>
<td>Discrimination</td>
<td>-.06</td>
<td>-.31</td>
<td>.28</td>
</tr>
<tr>
<td>Harm Reduction</td>
<td>.26</td>
<td>-.04</td>
<td>-.16</td>
</tr>
<tr>
<td>Epidemiological Monitoring</td>
<td>.24</td>
<td>-.08</td>
<td>-.11</td>
</tr>
<tr>
<td>Throughput Monitoring</td>
<td>-.21</td>
<td>-.13</td>
<td>.25</td>
</tr>
<tr>
<td>Formal Methods</td>
<td>-.09</td>
<td>-.11</td>
<td>.15</td>
</tr>
<tr>
<td>Informal Methods</td>
<td>.20</td>
<td>-.19</td>
<td>-.00</td>
</tr>
</tbody>
</table>

There are some differences between the agencies in terms of their preferred educational activities and evaluation methods. Some of these differences are explicable in terms of the nature of the agencies concerned. For example, primary exchanges were more likely than others to focus on Harm Reduction education activities and Epidemiological Monitoring and Throughput Monitoring evaluation methods. This makes sense in terms of the major activity NSPs carry out and their need to ‘count’ for monitoring and accountability purposes. Public sector agencies tend to focus on HCV knowledge, again not surprising but it is interesting that there is little evidence of an emphasis on any particular evaluation method. Finally, community organisations put an emphasis on Discrimination education activities, reflecting in part their advocacy role. It is interesting that they tend to rely on both Formal methods and Informal methods of evaluation. But none of these emphases is statistically significant, and this reveals a lack of major distinction between agencies in HCV/IDU prevention education work.

Analysis of variance demonstrated a significant difference between the agencies only with respect to Discrimination ($F_{2,115}=3.7$, $p<0.03$), which reflects an emphasis by community agencies on this topic and the relative absence of emphasis on the part of the public sector agencies. The focus on this issue on the part of community agencies is understandable; the lack of interest on the part of public sector agencies is worthy of further attention.

In summarising the findings of the survey, we would note the large number of education activities and the variety of evaluation methods indicate a very complex HCV/IDU education sector. There is a lot going on and educators are trying hard to assess the effectiveness of their work. The sector also includes a wide variety of agencies, large and small, both community-based and located within the public sector.
NSPs are clearly a very important part of the sector and their educational potential warrants further investigation. Many agencies are not specialising in HCV/IDU prevention education alone and have other pressing concerns. It will be a complex task assuring that the HCV/IDU prevention message is consistent across the sector for all those at risk of hepatitis C infection. This may make it somewhat difficult to achieve a unified national approach to HCV/IDU prevention education which can be readily applied across the sector. This difficulty is compounded by the diversity of target groups for educational programs. The approach to producing better practice may lie in embracing the diversity and complexity and not in seeking an artificially unified or singular approach to HCV/IDU prevention education. This issue will be explored further in Section 6.
5

Action Research Projects

5.1 Introduction

The action research component of the project was designed to amplify the information gained from other research methods by contextualising inside real agencies the themes emerging in general from those data, and examining the work with real educators as they went about their day-to-day work.

Action research is the opposite of experimental design in social research where researchers strenuously try to keep the research ‘object’ still and protect it from influences that might ‘contaminate’ those persons or things being examined or trialed inside the research process itself. Action research welcomes ‘contamination’, regarding it as an important aspect of the grounded investigation of the ‘real’. In these action research projects we did not know what might happen along the way. Disruption, unexpected influences and things ‘coming out of left field’ were met with an open mind on the part of the researchers and a willingness to accommodate them into the research.

One major disruption for the research was the withdrawal of one agency part way through the fieldwork, due to its internal difficulties. A replacement agency was recruited, but this restricted that section of project to a time line of less than half the other two. We are grateful to the first agency for giving it a try, and very thankful that the replacement agency was prepared to run a little faster to catch up. The material from this last-on agency is rich in ideas and thoughtful educational practice despite the short investigation, and it is discussed here as another example of the real work of action research.

However, what is often the unexpected for the researcher is merely an average event for the practitioner. Part of the researchers’ task is to document faithfully the responses of the practitioner and try to glean from it fresh insights into the practice developed by the practitioner at exactly that moment. In the case of these studies, focused on HCV/IDU educators, retrospective accounts were also used to gather information from the educators as we had under three months with each organisation (less with one) and could not hope to round out a profile of educational practice prospectively.

Much of what we found in these studies confirmed aspects of the picture developing in the survey and the key stakeholder interviews. But in these action research projects, what are lists of infrastructure, resources, funding, personnel, training issues and so on
emerging from interview material and survey data are embedded in, and converge to impact upon, the daily work of educators in real and concerted ways. There can be no abstraction here (although ultimately that is the researchers’ task), and we have tried to retain that sense of embeddedness in the account that follows.

5.1.1 The agencies

Three agencies took part in the action research component: (1) the Western Region AIDS Prevention (WRAP) program—a public sector NSP in Melbourne’s western suburbs; (2) a TRIBES-funded project, based at Foley House in Sydney, which produced ‘The Game’—a board game using prevention information developed by a group of young users; and (3) the Sunshine Coast Intravenous AIDS Association (SCIVAA)—an agency working with users, funded by Queensland Health. We are grateful to them for their participation and assistance in this project.

Agency selection

The agencies were selected with the assistance and support of AIVL. The three participating agencies were chosen with initial advice from the advisory committee which mapped the agencies according to a matrix outlined below. Selection of the host agencies involved a two-tiered process:

1. an initial round of national consultations (face-to-face and by telephone), which included gauging the willingness and viability of agencies to host a demonstration project;
2. finding an effective ‘mix’ of educational activity within each agency, including a suitable combination of program and educator characteristics that allowed both for sufficient variety and comparability.

A matrix of potential host agencies was formulated using five agency characteristics:

- geography/demography (e.g. urban/suburban/regional);
- mode of educational delivery (e.g. small media, outreach);
- organisational context (e.g. public sector agency, community-based);
- target groups (e.g. young users, steroid users);
- pedagogical techniques (e.g. team work, self-evaluation techniques, program planning activities).

The advisory committee requested that at least one primary NSP and one user group be considered as host agencies, given that most direct HCV prevention education among users occurs in these agencies. Finally, agency selection was modified by the feasibility of research staff regularly and easily accessing each host agency once the seconded educator was appointed.
5.1.2 Procedures

The action research component of the project involved the research staff and the educators from the three selected agencies working together to describe elements of educational practice occurring in their HCV/IDU prevention education. It took as a starting point the assumption that there is good educational practice already occurring in this field, produced by educators whose knowledge and skills have developed as a result of training, professional experience and/or life history. Educational skills developed within a peer-education model are highly regarded in the field and seen to be particularly effective with users, and the action research sought to uncover and record the elements of those skills in practice.

The research staff from time to time attended various educational activities associated with each agency, with the consent of the agency educators and the agency. Research staff also met regularly with the specific agency educator(s) for discussion and reflection on their educational practice and to document the key elements of this practice. In order to observe educational activities without disrupting or adversely influencing them, research staff participated as assistants to the agency educators in those educational activities chosen to be observed. On other occasions, research staff only observed the educational activity taking place. Wherever such observation occurred, it was conducted in an unobtrusive manner that did not disrupt or adversely impact upon the agency educators, their clients/participants or the outcomes of the educational activity. Research staff also attended various committee and agency meetings with the agreement of the appropriate agency staff.

5.1.3 Reflection

Research staff met regularly with the agency educators to discuss the educational components of the activities observed at each agency. These meetings were, in essence, opportunities to reflect on the ‘art’ or ‘craft’ of educating as practice and process—i.e. pedagogy—and collaborative explorations of the content, delivery and communicative forms (curriculum) and on understandings of educational interactions between educator and clients. This phase of the research was the crucial element of the action research model. Its purpose was to uncover and understand what it is about what educators do that makes education work.

It is also hoped that these moments of reflection produce subsequent effects in educational practice. This turns out to be harder to do that we imagined, or, more precisely, harder to observe so immediately and be certain of in a short time scale such as we had on these projects. But we did observe shifts in thinking and regard this as evidence of the effect of reflexive practice that informed the action research from the start. The feedback from the agency educators was that the moments created for reflection by and with the research staff were useful and a ‘luxury’ not often available in their daily working life.
A second purpose was to document practices of reflection, evaluation, development and planning that often go unnoticed and un-validated as real work in an educator’s day. This purpose is consistent with earlier research on educators (Connell 1985; Shaw & Dowsett 1986; McInnes et al. 1999) and to that end similar techniques were used to garner from educators’ ideas and practices the unnamed, the hidden and the less well-regarded aspects of reflexive practice in which they engage. A particular exercise, the ‘Grid Exercise’, was used with groups of agency staff in all three sites to do this. The ‘Grid Exercise’ involved participants in nominating practices, ideas, processes, activities and procedures on two axes: the vertical proceeds from the individual to the collective; the horizontal proceeds from the informal to the formal. Participants in group workshops are asked to think of all the things they do in thinking about their work and plot these on the graph.

<table>
<thead>
<tr>
<th>Collective</th>
<th>Informal</th>
<th>Formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

So, for example, a regular staff meeting might be plotted in the upper right-hand quadrant—a formal collective practice; thinking in the car on the way to work would be plotted in the lower left-hand quadrant—an informal individual activity, and so on. The object of the exercise is to build up a picture of the whole agency’s reflection practices, particularly concentrating on those not normally recognised as processes and practices of reflection.

**Document collection**

Research staff also collected, where possible, various documents and written materials used in or which detailed educational activities carried out during the life of the action research fieldwork. These materials were not intended to assess educational practice or to reflect some kind of product of pedagogy. Instead, they were solely for research purposes—for collaborative reflection with the agency educators to identify
educational practices, to assist in research analyses and to document the educational initiatives being investigated. Field notes, observations and discussions about education and evaluation techniques were recorded through written notes by research staff. When note-taking was inappropriate to an educational setting, the notes were recorded at a later time.

5.1.4 Research relationships

Conducting this form of action research involved a steady process of relationship-building with all involved. For example, there is often little demarcation within a NSP as to who does or does not deliver education, and research staff rapidly had to establish a rapport with all NSP workers. Opportunities for direct HCV education in such a hectic environment would at first appear to be limited, but closer scrutiny revealed a number of ways in which all staff interact educationally with the NSP clients. For instance, a mapping exercise, involving all full- and part-time WRAP staff, identified various ways in which knowledge was gained and education practised in that NSP and highlighted the fact that NSPs have direct contact with the largest number of users.

‘The Game’ facilitated a more orthodox educator/researcher dynamic and, in turn, has allowed for a closer investigation of the educator’s effectiveness. Working alongside both the educator and young users, research staff witnessed a substantial growth not only in the agency educator’s capacity to educate, but also in the young users’ ability to ask questions of themselves about the way they learn and how they might go about their own peer education.

5.1.5 The elusive educational moment

If one thing emerges from this action research, it is how elusive the educational moment is. This is not just true for the researchers but for the educators also. In the hurly burly of daily educating, what often intrudes are those issues that structure, yet are peripheral to, the educational moment: problems of resource shortages, institutional politics, environmental difficulties, the illegality of drug use (and police can exacerbate this problem), issues in clients’ lives over and above drug use, the consequences of drug use itself, policy decisions that are incomprehensible when faced with daily education tasks (e.g. the restriction on condom distribution in Victoria, the wide-bore needle withdrawal in New South Wales), and so on.

In the face of these contextual and structural factors, educators themselves when interviewed also turn their attention to these, because they know through experience that these factors have a direct impact on their ability to do their jobs. Yet, in concentrating on these difficult factors (and they are almost always difficult), the educators (and researchers as well) often bypass the educational moment, and avoid the examination of pedagogy itself that focuses on their most valuable assets and resources—the creative moments in the art of teaching.
Often that magic educational moment also eluded us in this project, although there were glimpses at times in the creative responses educators had to certain situations to provide us with sufficient fuel for a continuing search for it. We shall concentrate this account of the action research component on those creative instances where they shone through the fog of factors that confound the educational moment, but will record the dominant structural factors reported and observed as well.

5.2 Discussion of the action research

We offer here a summary of the key points arising from the action research component of the project. Other broader conclusions from the action research component are included in Section 6 of this report. The detailed accounts of the three action research projects are presented in Appendix 5.

5.2.1 Qualities of the educators

The following emerged as key qualities in the educators that are necessary for effective education:

- the importance of knowing, and getting to know, clients
- the critical importance of being non-judgmental and trustworthy;
- the ability to initiate conversations even when clients want rapid entry and exit from NSP sites;
- the valuable contribution of an educator’s own life experience and understanding of users, often (but not only) as users or ex-users;
- the capacity to admit knowledge gaps and ask more experienced colleagues for advice.
- the need for, and relationship between, formal education and training as well as ‘on the job’ experience/apprenticeship.

The central issue here is the skills required to engage a client or a group of users in an educational interaction, whether the brief provision of injecting equipment or a sustained process of producing a resource. Educators in all three agencies recognised clearly that in the interaction they needed to appear equals of their clients. While giving information, expertise and advice were seen as part of the job, the delivery should not be didactic. This required considerable skill and a fair degree of familiarity with using and IDU issues. Tensions emerge on this issue in relation to an educator’s current or previous experience with using themselves. This issue will be explored further in Section 6.

A second aspect of educators’ work that became clear in the action research is the very ‘human’ nature of this work. Clients are whole persons for these educators, not just an identified or expressed need to be met with a pamphlet or equipment. The emotional and psychological energy invested by educators in their interactions with clients was considerable. Apart from educational and technical skills, these educators need
interpersonal skills, something not always openly acknowledged. This is an aspect of their work often forgotten and rarely planned for.

The need for such skills goes beyond their use in interactions with the clients. They are necessary for a range of community and interagency liaison activities that every educator seems to do as part of the job, whether in the job description or not, and usually not funded by the funding authority. This liaison work is vital to each program’s survival particularly where communities and neighbourhoods are either wary of or dislike users and the presence of the program or agency, and especially when the issue of equipment disposal arises, as it always does. This kind of liaison is inevitable but rarely seems to be adequately resourced. Another concern is the police and their regular activities that are perceived by educators to be directed toward harassing users, requiring of educators and agencies some deft liaison and occasional damage control to rebuild client confidence in their agency.

It is clear from the educators’ daily work observed in the action research that they must be both professionals and peers at the same time. There is confusion about this issue not just in educators’ minds but also in the aims and objectives of agencies themselves. Educators must act as professionals in their dealings with those other health workers, local communities and various agencies such as the police. They must also be professional in how they do their jobs. Yet they must approach any educational moment appearing as an equal of their clients—a ‘peer’ as it is often called. In fact, in the three agencies there was little ‘peer education’ happening at all. The only definite example occurred in the TRIBES project, ‘The Game’, when the young people involved as clients became peer educators and conducted workshops for other young people.

Given the very strong belief in peer education in the sector, its absence in the action research raises a question about what peer education actually is. The educators clearly do have skills, knowledge, training and experience to contribute to those interactions with clients which in effect make these interactions unequal. There is a hesitancy in the sector to recognise this distinction between an educator and a client and work with it. Some educators refuse the notion of peer, understanding that what they do is an intervention in clients’ lives. Others cling to an idea of peerdom at odds with the actualities of their daily work. There is a need not to confuse a democratic way of working with clients with naïve notions of peerdom. This is becoming increasingly important in the light of a burgeoning workload.

Another major aspect of educators’ work that emerges from the action research is its rapid growth in terms of number of clients, turnover of activity and volume of equipment requested and distributed. This research project is not in a position to ascertain whether funding from Commonwealth and State/Territory Governments is keeping abreast of this growth. However, it is clear that the educators are under increasing pressure to do more. The high staff turnover noted in all three action research sites at both educator and at program manager or coordinator levels would seem, in part, a product of the degree of stress accompanying this growth and with
stretching resources, both human and financial, to meet this need. In some cases it was clear that the performance goals expected of the agency cannot be achieved no matter how hard the educators work.

5.2.2 Reflexive practice

The educators are meeting these challenges with tenacity and innovation. The ‘Grid Exercise’ revealed considerable reflective activity in which educators try to nut out solutions to problems of practice. Sometimes these relate to individual clients, e.g. remembering movies or rock bands they like to jump-start conversations. Sometimes they are strategies for extending the interactions with clients in the hope of squeezing in a little more education and information, e.g. one NSP worker did not have injecting equipment pre-assembled in packs—he used the assembly time to engage the client in conversations about safer using etc. This type of innovation deserves to be supported and needs encouraging. The array of such tactics and reflection practices, detailed in Appendix 5, indicates considerable resourcefulness already in operation and awaiting development to produce even more effective practice through better and more integrated reflexive practice and curriculum development. These issues will be discussed further in Section 6.

The interviews with the agency educators and the group exercises undertaken by the research staff with them, in particular the ‘Grid Exercise’, revealed numerous moments of reflection that are part of the intrinsic drive to quality of these educators. We summarise these briefly below in Table 13.

Table 13: Action Research ‘Grid Exercise’ Summary

<table>
<thead>
<tr>
<th>Collective</th>
<th>Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>Networking</td>
<td>Planning</td>
</tr>
<tr>
<td>Group discussions</td>
<td>Networking/interagency</td>
</tr>
<tr>
<td>Informal orientations</td>
<td>Staff meetings</td>
</tr>
<tr>
<td>Talking—‘smokers’, coffee, social</td>
<td>Collective work activities</td>
</tr>
<tr>
<td>Talking with friends, partners</td>
<td>Designing resources</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Informal</th>
<th>Formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thinking about work out of hours</td>
<td>Research (doing, reading)</td>
</tr>
<tr>
<td>Working at home (different environment, creative space)</td>
<td>Reading</td>
</tr>
<tr>
<td>Meeting clients outside of work</td>
<td>Internal/external supervision</td>
</tr>
<tr>
<td>Personal experiences/development fed back into program</td>
<td>Message/incident book</td>
</tr>
<tr>
<td>Reading—work-related and general</td>
<td>Learning directly from job activities</td>
</tr>
<tr>
<td></td>
<td>Client contacts</td>
</tr>
<tr>
<td><strong>Individual</strong></td>
<td>Networking</td>
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Even though the items above appear unsurprising and quite comprehensible as being a logical part of any educator’s day, it is clear that these rarely form part of any systematic process of reflection producing associated changes in practice. It is surprising how few of this activities were explicitly planned into programs. The ‘Grid Exercise’ did produce an effect during the action research, indicating the value of using such techniques of reflexive practice. The educators themselves noted how little time there is for developing such reflexive practice in their agencies at present, and this issue will be discussed further in Section 6.

5.2.3 Contextual and environmental issues

There are clearly significant infrastructure issues for the sector. Some of these are:

- the vital role of an NSP’s environment in interactions with clients—allowing space for clients to access injecting equipment and still have time to ask questions;
- worker/staff frustration at not having more opportunities and space to conduct group sessions;
- difficulties in ensuring staffing continuity;
- the lack of sufficient user advocacy groups and community awareness of the role of NSP;
- the difficulties in developing meaningful interactions with CALDB clients.

There are a number of other features in common in all three action research sites. The agencies all battle with inadequate facilities and less than supportive locales. This makes their work doubly difficult. There is a need to obtain a clearer assessment of the extent of these problems and to develop strategies to deal with them. Also, they are all under-resourced in relation to the tasks they are either contracted or try to undertake. These shortages occur in staffing levels for the services to be supplied, in administrative support, in funding for resources supply and production, in demands to provide training for other health professionals, and in funded time for necessary advocacy and liaison work. WRAP indicated that their work is hampered, for example, by space considerations and the demands on staff time for community liaison, etc. There is a strong sense in all three agencies in the action research that, to a certain extent, they were working with one hand tied behind their backs. These contextual elements compound any particular environmental deficits and geographical demands.

There would seem to be a need for more interagency collaboration and cooperation, particularly when an educator is the only one doing HCV/IDU prevention education. Where such interagency activity was in evidence, educators and clients benefited. There may be efficiencies to be gained here as well as better dovetailing of programs and assessment of clients’ needs. This cooperation extends to the education of other health professionals being undertaken by HCV/IDU educators in the action research sites. The contribution of these educators is valued, but it does stretch their resources thinly and the programs are not adequately funded to provide the time and preparation needed to offer such training. Moreover, services to clients suffer if educators are pulled out of programs for other purposes. This issue will also be discussed in more detail in Section 6.
Finally, the action research revealed something about the value of such research itself to educators. It is a style of research that can be used at the local level for different purposes and can involve educators in investigative and reflective activity that is of value. The researchers learned much from having a seconded educator as part of the research team as well. Previous research projects in the agencies had had similar effects at times and this points to the usefulness of grounded research that involves agencies and educators as partners of various kinds. Encouraging more research of this nature would be useful to the sector.

Consideration of these issues will be returned to in the next section of this report as part of the discussion of findings from the research project as a whole.
6

Discussion of Interviews, Conclusions and Recommendations

6.1 Introduction

The purpose of this section of the report is to present findings from a series of in-depth interviews conducted with key informants from each State and Territory with a view to exploring the contexts of HCV/IDU prevention education and to amplify a number of the themes that emerged from the national consultations, the survey of current interventions and, where appropriate, insights gained from the action research. No separate section is presented discussing the findings from key stakeholder interviews on their own. The reason for this is that as the analysis of the key stakeholder interviews proceeded it became clear that the themes emerging were already dovetailing with those developed in other parts of the methodology. This suggested an integrated analysis as the best way forward. Therefore, in this section of the report we explore these themes referring at times to evidence from all parts of the methodology and present from that analysis various recommendations for developing better practice in HCV/IDU prevention education in Australia. However, all quotations in this section of the report are from interviews undertaken with key stakeholders.

There is considerable enterprise and energy in the sector and widespread support for taking on hepatitis C, particularly in response to the extra resources recently made available. Although there is still pessimism that hepatitis C prevention is possible, most key stakeholders regard it as important to try and would support the thrust of the recommendation by Lowe and Cotton (1999:131ff) that the national effort be enhanced. Educators are also concerned about their quality and effectiveness of their work and that of their colleagues and actively welcome the potential for improvement. The sector is not resistant to change.

That said, with surprising consistency a set of themes emerged from these data which point to an almost standard set of difficulties that beset the field, most notably a shortage of financial and human resources. The survey found that only 13.5% of agencies had more than six full-time staff working in HCV/IDU prevention education (mainly the public-sector agencies), and nearly a third (31.3%) had only one person working full-time in the field. In many cases, this worker had other responsibilities. Part-time staffing was more common (see Table 3 earlier in the report). These staffing levels are clearly insufficient given the magnitude of HCV/IDU prevention to be undertaken (e.g. it has been estimated that there were between seven and nine million
injections in New South Wales in 1994-95 and between 65% and 83% used a new syringe (National Drug and Alcohol Research Centre 1999). Similarly, where separate costings were ascribable to individual HCV/IDU prevention interventions (37% of activities), only eight had a budget of $100,000 or more and only seventeen had a budget of over $40,000. These are not ‘big ticket’ public health activities when staff salaries are subtracted, and this reveals the (small) scale on which the sector works.

The scope of the human and financial resources needed in the sector is beyond this project’s brief and is best left to others. However, the sector’s basic infrastructure needs do require addressing.

R1. We recommend that a national infrastructure benchmarking study be undertaken, particularly in the community-sector agencies and the NSPs to assess the basic resource requirements for supporting the educational activities of the sector.

The issue of human resources, however, is central to our concerns, and that domain of inquiry yielded significant insights into the process of HCV/IDU prevention education and the major elements of its pedagogy. There is no doubt that there are excellent educators in the field and that they work hard in trying to understand the educational dynamics underpinning their daily practices and programs. And there is a diversity of evaluation methods being tried. The large variety of activities revealed in the survey and the range of modes of delivery are impressive. One educator pointed out that they must have been doing something right educationally all this time: the low HIV prevalence sustained among users proves that!

6.2 Just who are HCV/IDU educators?

Yet somehow, I’ve ended up as an educator, and it’s something that’s important to me: to be a good educator and to do it well. And it’s something I take great pride in...I’m passionate about these issues. They are important issues to me. I got there by default. It’s not where I expected to find myself. It’s just a set of, you know, just like life is a chain of coincidences, I ended up with, um, this job.

This educator is not unlike many who have found themselves working in IDU education since the HIV epidemic began and who have now taken hepatitis C on board as well. This study did not attempt to ascertain just who constitutes the full HCV/IDU prevention education workforce. ¹ However, the Activities Questionnaire did allow a brief glimpse of that workforce, and the national consultations and key stakeholder interviews revealed some common attributes of the workforce, particularly of those working in the community sector.

The survey found that 58.3% of HCV/IDU prevention education activities reported were provided by peer educators. This finding does demand a recognition that peer educators are an essential part of the prevention education workforce.

¹ That task is currently underway as part of the Community Education Workforce and Training (CEWT) project, being undertaken by ARCSHS in conjunction with the University of Western Sydney, Nepean.
education is an important mode of educational program delivery. But it is by no means the only mode. A substantial minority of activities (41.7%) were not peer-provided. This is, in part, due to the public-sector agencies involved in the survey (correctional services, regional health units, etc.). It is also a product of the embeddedness of many HCV education activities within other services and programs: alcohol and other drugs, sexual health, HIV/AIDS, counselling and so on. Any new initiatives in HCV/IDU prevention education will need to recognise a wide variety of institutional contexts, many of which will not share the same agenda or priorities. Given that diversity, it will be important that HCV/IDU prevention education initiatives do not create more ambiguity or confusion among users by focusing on only one part of the sector, or developing new messages or approaches that apply only to one institutional site or context.

Within the peer-delivered activities, as noted earlier in Table 6, 17.6% were provided by peer educators who were current users, 6.5% were provided by ex-users, 3.7% by same social group peers (e.g. gay men), 18.5% by current users also belonging to the same social group, and 12% were provided by an aggregation of ‘other’ forms of peer-based activity. The key stakeholder interviews added further dimensions to this picture of HCV/IDU educators. Being a user (and, for some, an ex-user) was regarded as an important claim to authenticity as a IDU educator. There was by no means a consensus on what this authenticity entailed or meant, but the 1999 National HCV Educators Workshop feedback session undertaken by this project drew important support for the idea that users as peer educators do their best educating when they are using with their friends or in their own using networks. This issue will be discussed later. It suffices to say here that many HCV/IDU educators bring a strong personal history and experience of using to their work as a result. This is an important resource to the sector. Another aspect of this proximity to IDU is the using networks that educators who are users bring to the work, both in subcultural familiarity (understanding its rituals, process and forms of using) and with links to potential peer educators or clients involved in the program being offered by that educator.

The second noticeable characteristic of many key stakeholders is their long experience in the field as volunteers, HIV/IDU educators, NSP workers, activists establishing/working in user groups, and/or in community sector work of various kinds. Less common was professional training in allied health fields, e.g. nursing or health education. There was also little research, policy and public sector experience. Finally, a number revealed that they were either HCV positive or HIV positive and a few were on various treatments regimes for HIV infection. This deep personal experience of the epidemics is also clearly an important resource for the sector and guarantees that the ‘partnership’ in HIV/AIDS and now in hepatitis C with affected people is still meaningful.

2 The questionnaire allowed respondents to choose to categorise themselves as peers or not, and there was no question that clarified the reason for that choice. The questions did not attempt to clarify what was meant by ‘peer’.
6.2.1 Training

There was a small number of educators interviewed who regarded themselves as ‘professional’ in that they had university degrees and saw their work more in terms of evolving careers. While some of this tertiary training was directly related to their work (degrees in adult education, nursing, social work) and some had completed either diplomas or short courses to build their skills, almost all key stakeholders claimed a central importance for on-the-job experience (over and above any using experience). This is an important claim. It tells of the newness of the field itself and of the growth in user education since the advent of HIV/AIDS (and now hepatitis C). In a sense, it also registers one difference between the community sector and the more usual agencies working in IDU health, viz. the alcohol and other drugs field.

There is some difference of opinion on what constitutes good IDU education (whether in HCV or HIV, in prevention or health care/support, and in treatment) between those educators who have formal training and credentials and those who have grown into their jobs within the sector itself. But the main issue is that lack of training specific to HCV/IDU health education. This suggests that a training agenda may need to be developed specifically to suit the needs of educators in this sector, particularly its community-based workers. Any such training agenda needs to recognise the importance of on-the-job training and find a way to utilise its benefits and strengths. This has implications for any future national training agenda for community-based health educators and suggests that a single mode or system of training may be inadequate. Moreover, the sector is diverse, with NSPs, user groups, public sector agencies, alcohol and other drugs services, a variety of gay/HIV organisations, and those targeting special groups (young people, Indigenous Australians, CALDB communities, etc.). No single training agenda will satisfy this diversity. The agencies involved in HCV/IDU prevention education are so varied that no single training mode would work.

Self-directed learning models for ongoing training would be most suitable basic model for this field. This should be based the principles of adult education, which allow for the HCV/IDU educators to participate in designing and undertaking their own training processes. Inputs to this training need to draw on three forms of knowledge already available and valued in the sector: (1) experiential knowledges (educators’ experiences as users and/or as member of a particular community or population); (2) professional knowledges gained in pre-service training; and (3) formal knowledges in the field (research outcomes, evaluations, epidemiology, etc.). Some documentation of the competencies required to do the job well in the various parts of the sector would also be useful to guide the development of the training agenda.

R2. We recommend the development of a national HCV Educator Training Agenda (HETA), based on a range of processes: on-the-job activity; short courses; and competency and credentialled courses where appropriate. To achieve this, we recommend a demonstration training project be developed specifically to test models of on-the-job training, particularly for the community sector agencies and NSPs. This would operate alongside any other training initiatives in the national training agenda.
6.3 Peer education—who is a peer?

When pressed, respondents always nominated ‘peer education’ as the most important form of education for users.

I think the ones that I have seen work really well are peer-based, where the peers not only do the education but decide on what the education’s going to be—do the whole thing from woe to go, go to woe.

The strong and broad support for peer education was evident both in the literature and among practitioners. This support often lacks a consistent definition of peer education and is underpinned historically by many of Australia's national public health strategies where the involvement of affected populations and communities is guaranteed as a fundamental element in approaches to prevention, care and support. However, the principle of involvement of affected people in public health policies, processes and programs is quite different from the notion of peer education as a form of health promotion delivery. They are not the same thing and should not be confused. The principle of affected-population involvement by itself does not justify a reliance on, and defence of, peer education as a specific form of pedagogy. Peer education has to stand as a pedagogy in educational terms.

While it appears almost heretical not to support peer education, there was no agreement as to what a ‘peer’ is. Often a peer was described as a fellow user and peer education was, by default, education done by users for/with users. Few other distinctions were made. Some respondents even questioned the concept of peer whenever other social characteristics of users were introduced:

I’m certainly not a peer of a body-building steroid user. I'm not a peer of a seventeen-year-old street heroin user. I'm not a peer of most of the injecting drug users in the world, um, but I can be called a ‘peer educator’. It’s quite strange.

This comment begs the serious question about whether using, in and of itself, provides a social binding sufficient to override or offset the effects of powerful social structures such as age and generation, race and ethnicity, class, gender, sexuality, space and location. There were other comments about the looseness of the term when applied, for example, to half-day trained NSP volunteers—a usage that diminished the real qualities valued by the educators in the idea of peer education:

The idea that you train people up to be peer educators and they get to wear tee-shirts and be peer educators is just so bloody offensive!

Beyond the issue of who is a peer, there were strikingly contradictory accounts of the contribution and importance of current or previous drug injection experience among prevention educators and other HCV/IDU workers. Usually, this idea of being a current or ex-user was mentioned as the key criterion for establishing peer relationships with users/clients. This was argued in terms of the value of having an intimate knowledge of the choreography of drug injection (the intricacies of a drug...
injection event from original intention to cessation of effect), and also in terms of nominating important educational moments as:

...when they’re [the educators] using with their friends and you’ve got all that pressure on [you] and everything: ‘Why are you doing that?’ ‘I’m doing that because, you know—but it’s—don’t care how busy I am, I’m still gonna swab my spoon!’...peer educators do their best work when they’re not at work.

However, if this was a prevailing view, some equally experienced sector workers were less certain:

Well, I would say that most injecting drug users are unsuitable to be IDU peer educators. They are suitable to be peer educators within their own environment, their own client group...They are not suitable to be IDU peer educators on a paid capacity because they have um...how do I put it? They have trouble separating their work from the lifestyle.

There is considerable agreement that such using experience does ground the educators’ understanding of their pedagogy squarely within an intimate knowledge of using. This has become more vital as the exigencies of HCV transmission are more complex than those of HIV and have been shown to require a detailed understanding of choreography of drug injection, in order to ensure every potential HCV transmission moment in the choreography is scrutinised for risk and actively considered by users.

Part of the claim to, and support for, the notion of peer comes from some resistance to formalising HCV/IDU education and a suspicion of claims to being an ‘expert’. There are diverse grounds for this: sometimes a recognition that good educators do not pretend to ‘know it all’, and partly an idea that an expert is not a ‘real’ peer. Yet, there is a contradiction here. Education (of any kind) is an *intervention* in people’s lives—it always has been. Expertise is important in ensuring well-planned and executed interventions and, as one key stakeholder noted, users themselves would appear to recognise the value of expertise:

They don’t want some dumb junkie telling them this is [the] pharmacology; they want an expert ’cause their lives depend on it.

It is important for educators in the sector to recognise the value in expertise and not confuse that with acting the expert in bad faith. This confusion is understandable as:

[being an educator is a type of performance. When you think of the best educators—I mean the people who are, sort of, up there in my, sort of, top ten of best educators—they’re also consummate performers.

Good performance requires skill and knowledge—it requires expertise—and does not necessarily detract from the capacity for democratic relationships between educators and users.

There is consistent reporting, however, that most agencies do not deliberately recruit staff only on the criterion of personal drug injection experience. This is, however, one
consideration among others and acts as a kind of shorthand for a more complex set of concerns about the capacity to deal with drug use dispassionately and with users non-judgementally (a uniformly reported requirement) because:

Injecting drug users have an uncanny ability to detect bullshit in a short space and time. And they can detect whether you have learnt it from a text book or you have some personal experience. Even if you’re a very well-meaning non user who has all the right information, you still won’t be able to discuss the nitty gritties with them, because unless you’ve actually mixed up or had some of those issues to deal with, you can’t offer practical information on how to deal with those situations.

This would appear an irresolvable difference of opinion. There is even a tension between users and ex-users in which the latter are seen as likely to be increasingly out-of-date with contemporary drug cultures. It is clear that ‘authenticity’ is at the basis of this aspect of the claim to peerdom, invoking various and divergent criteria, and one underpinned by a palpable concern with the legitimacy of drug injection itself. The legitimacy of IDU is not the concern of this report. Our concern is: what is the educational issue at stake? Can using, in and of itself, be the basis of a pedagogy or is it just the lowest common denominator in peer education?

6.3.1 Ways of using

Clearly, using cannot be the only criterion for, and claim to, the idea of peer even within the notion of peer education, as other determinants will prevail at many times (e.g. ethnicity is one already recognised in CALDB-focused HCV education). Also, that many respondents recognised the ‘subculture’ logic of the various highly regarded TRIBES projects attests to this awareness among HCV/IDU educators themselves. Other respondents noted that drug use is a very changeable cultural phenomenon and ways of using (Sharp et al. 1991) transform rapidly and go out-of-date. Even experienced users (not just ex-users or non-users) may not fully comprehend an emerging subculture as readily. Does a steroid-using body-builder understand a ‘feral’ user or ways of using at a ‘rave’ party?

This notion of ways of using offers one way to re-think drug-using. It is as concerned with what one does and can do in using as well as what is and should not be done. It suggests that there are many subculturally formed patternings of drug use and, while some of those patternings have common elements related to the drugs being used, other expressive and interpretive forces contextualise that drug use. Recognising the specificity of ways of using, over and above any commonality related to the drugs used, will provide significant ‘raw materials’ for educational interventions particularly when working with recognisable user networks (see later). This has been noted in parallel debates on erotic imagery in safe sex education for gay men (Devell & Rooney 1994; ANCARD Education Subcommittee 1999) and in BBV prevention
education in relation to young people. The significance of ways of using in relation to HCV/IDU prevention education is that it surpasses any simplistic notion of peer as a singular characteristic and embeds peerdom in a complex picture of subcultural formations in which drug injection forms an element. The concept of ways of using recognises the very different choreographies available in using and their subcultural loci. Ways of using also provides a conceptual basis for some client assessment tools and a potential logic for any future social research undertaken to assist the sector.

Many of the agencies delivering HCV/IDU prevention education are not peer-based user groups, will never be so, and do not claim to offer peer-based education programs. Indeed, one user group argued forcefully that it did not do peer education at all. So, peer education as a pedagogy will not be the only model to invest in. While it should remain a core pedagogical form in user health education, producing better educational practice across the sector will be achieved by supporting a number of different educational models, including peer education.

But all forms of HCV/IDU education will need to understand and utilise the ways of using of their target populations if they are going to get the register and pitch of their interventions right. Peer education, as a major pedagogy, will best be utilised where it suits the type of agency and its type of work and where there is a sufficient intersection of social and cultural commonalities offering real opportunities for developing educational relationships between educators and clients. Using will undoubtedly be one of those commonalities but rarely the only one.

R3. We recommend a new ethnographic research project, undertaken with user groups along action research lines, to identify and explore a number of predominant IDU subcultures in at least three sites. The project will explore recent shifts in ‘ways of using’, and develop simple research and analysis techniques for identifying ‘ways of using’ in local contexts, which would be useful to educators as one tool for assessing target audiences and local needs.

The non-employment of peer-education as pedagogy in certain IDU agencies does not disturb the underlying principle in today’s public health of ‘partnership’ and the participation and consultation of users in the design, delivery and evaluation of HCV/IDU prevention interventions. Only a third of agencies reported users on consultative, advisory or management committees (the alcohol and other drugs sector notably lacks such participation), so there is considerable scope for stimulating the development of strategies of consultation and participation in the sector.

A number of educators themselves provided further uncertainty in relation to the notion of ‘peer’ by arguing that the moment a user is trained as a peer they move to being a worker, a ‘user educator’, even a ‘peer professional’. Others spoke of educators as ‘role models’, suggesting thereby that these workers take on a responsibility and a set of tasks that mean they are no longer merely or naïvely equal

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3 Personal communication from the project on a National Framework for BBV, STD and Sex Education in Australian High Schools (in preparation).
members of their social group. They are now ‘change agents’ working in a client group. Such educators are effecting change among their clientele—be it in knowledge levels, safer using practices, or community development activities. In this sense, these trained educators now mediate the relationship between public health imperatives and any agency’s client base (see Dowsett & Davis 1998). Embracing these ideas—which position the educator as ‘active’ not merely facilitative—will be important in developing a safer using culture among users, one which focuses less on producing individual behaviour change and more on achieving mutual safety and support among user networks. It is that mutuality that will allow peer education to do its best work.

The active educator is the key element of the professionalisation seen in the community sector, in HIV/AIDS in particular. Professionalisation, in this case, is not simply an issue of qualifications and certification, or working conditions and pay scales. It is also about the structuring of the relationships between worker and client. Therefore, there needs to be a redefinition and redeployment of the notion of peer education in HCV/IDU prevention education, one that recognises the difference between interventions primarily geared toward securing users who change using practices themselves and among their social or using networks as peers (as a result of whatever educational or behavioural impetus) and the activities of educators who recognise the need for, then devise and undertake those educational activities that produce such changes in groups of users. These are user educators—a term quite a few respondents employed—and these are the key workers in the sector. While peer education strategies will continue to be part of the pedagogic repertoire of user educators, the key investment in procuring better practice in the sector should be made principally in these user educators.

The wariness of professionalising and formalising IDU education is useful, as we are not recommending that any generic form of health promotion training or modelling be applied to the sector. Rather, we argue that the sector actively develop its own sense of professionalism through on-the-job training (see above) with its own competency standards, and embrace the notion of the professional user educator.

In relation to securing better educational outcomes from the efforts of user educators, one or two key stakeholders raised the question of performance assessment. This is another element of growing professionalisation and should not be avoided. The National Public Health Partnership framework is looking now at strengthening the workforce in public health and user educators should take that opportunity as a resource to develop quality in the sector. The development of the national training agenda, recommended above, needs to take on this issue.

Securing better educational outcomes also raises the further question of performance management. The national consultations and the key stakeholder interviews often drew comment on an ongoing saga of getting—and keeping—managers and coordinators. As a result, there is considerable instability in the field, particularly in the community-based part of the sector. There is an urgent need to attract and train managers and coordinators, particularly in relation to educational activities, and to provide sufficient resources to create career paths that will enable the sector to retain its skill levels and attain more continuity in program management. Specific training in
program management and coordination, suitable to the sector, needs to be developed, which also offers the chance for experienced educators to gain a credential of some kind.

R4. We recommend that the national infrastructure benchmarking project (see recommendation 1 above) take the issue of program management and coordination as one major focus.

6.4 The curriculum of HCV/IDU prevention education

In the absence of a training agenda and adequate educational research support, many educators—but not all—have, over time, ‘grown’ their prevention education activities from their intimate experience of drug injection and that of their own social network of friends and fellow users. Much has been developed also in response to HIV/AIDS. This has proven an excellent source of detailed knowledge of potential transmission risks, with educators contextualising HCV prevention messages within a range of strategies devised to teach users safer using techniques, vein care, safe disposal, and risk-related issues in terms of HIV and sexual activity.

That broad range of educational concerns was found in results from the Activities Questionnaire and summarised earlier in this report. This breadth of concerns was confirmed by key stakeholders who argued forcefully for a holistic approach to user education, one that did not seek to partition HIV from HCV, prevention from health enhancement, or life and personal skills from support in relation to other social problems (homelessness, sexual health, unemployment, etc.). This plea for an educational agenda that does not focus only on the ‘disease’ but also on the client as a whole person is not inconsistent with broader public health goals. It echoes a shift from the kind of disease-specific prevention education that HIV/AIDS generated and which is now also changing in the direction of more holistic public health approaches, particularly in relation to broader sexuality and sexual health issues.

It is obvious that many agencies delivering HCV/IDU prevention education are not, by and large, single-purpose agencies focused only on that issue. The HCV/IDU prevention education able to be undertaken in an agency whose core business is sexual health, for example, will be different from that offered by user group. Similarly, a NSP will be able to enhance its educational approaches quite differently from correctional services (particularly as long as NSP is not available in correctional institutions). Similarly, users will approach agencies for different purposes: for example, those seeking treatment for drug use will need programs different from those sought by users wanting information to assist them in making their using safer in relation to HCV.

This argues against a single or common educational approach and for the development of an approach to HCV/IDU prevention education that offers consistent messages and information on BBV transmission and the identification of risky practices, but within a range of pedagogic modes, suited to the agencies involved. This need for a range of pedagogies, based on the educational activities developed to date.
and framed by the persuasive argument for a focus on whole persons constitutes the basic structure of a HCV/IDU prevention education curriculum.

R5. We recommend that HCV/IDU prevention education be contextualised conceptually and in practice within a broader framework of IDU health education.

A focus on users as a population makes more sense within public health, particularly as the various national health strategies in HIV/AIDS, hepatitis C, sexual health and illicit drugs become more integrated within the National Public Health Partnership framework. Concentrating only on HCV transmission education without contextualising it within other health needs of users would waste a significant public health opportunity.

6.4.1 The educative moment

The craft of teaching is hard to describe and even harder to understand. Indeed, good educators are seen as instinctively able to practise their craft effectively. Yet, good educators are not born but ‘made’ in their training (formal and informal) and in their day-to-day practice (Connell 1985; Shaw & Dowsett 1986; McInnes et al. 1999). This project, in the short time we had, tried to uncover some of key elements of the practice of better education and evaluation in the HCV/IDU field. That task remains incomplete and only a longer study and efforts similar to those undertaken to investigate school teaching would yield a full (or fuller) account. However, we did uncover much that was of value and report on this under the following headings: information; transforming the message; modes of delivery; key educational program elements; and outreach.

Information

There is a commonplace legacy from HIV/AIDS education that pervades HCV prevention education which is that knowledge (or information) does not directly produce behaviour change. Indeed, many models of health promotion seek to explain complex relations between the two, and many policy makers to their endless disappointment seek comfort in the prospect of that direct relationship.

That such behaviour change (particularly conceived of as an individual decision and subsequent change in practice) constitutes the key outcome of education is not unreasonable, but it remains an unproved relationship. We are not so sure that it needs to be proved. No one asks the whole schooling system to prove that it is completely effective. As a society we are content, it would seem, that most young people completing twelve years of schooling do not actually get through their final outcome evaluation (various Year Twelve public examinations) sufficiently well enough to undertake university studies. Yet, we still generally believe that schooling works. It may be that in health education we have to learn to live with the imprecision of the craft of educating and not attempt to transfer from positivist biomedical and
behavioural science the demand for clear cause-and-effect, incontestable correlation and linear outcomes.

It remains clear in schooling that, no matter what else goes on and no matter what critique of teaching holds fashionable sway at any given moment, knowledge is incontestably central to educating and forms the raw material then woven into learning by students with the help of educators. Information is this raw material and, together with the learning processes devised by educators for their students (or clients) to undertake, forms the basis for any curriculum.

It is clear from this study that the parameters of the HCV/IDU prevention education curriculum are yet to be determined and settled on. While the recent review of Australia’s response to HCV (Lowe & Cotton 1999:16f) recommended that education programs be directed toward reducing the ‘prevalence of unsafe injecting and the prevalence of injecting’, there is by no means a consensus among user educators that both these issues constitute the educational agenda. The current National Education/Prevention Program based at AIVL is well along the way to developing nationally consistent information for HCV/IDU education. This will provide a solid foundation for the next step: moving from the content of education to the full curriculum development process recommended below.

Transforming the message

All educators interviewed regarded information provision, and getting the information right, as vital. There was common acceptance that users, while well aware of HIV and safer-using practices, are as yet largely ill-informed of the additional aspects of safer using in relation to hepatitis C. That knowledge and understanding is present among some, but the consensus was that a more than patchy coverage of users as a population has yet to be achieved. That we lack a clear understanding of the user population in Australia (estimated at approximately 100,000 regular and 175,000 casual users) is only part of this problem.

Some key informants suggested that the shift from HIV-related using messages has yet to occur far beyond the agencies themselves and that the key messages of harm reduction in relation to drug injection and HCV infection—in short, the shift from ‘safer using’ to ‘blood awareness’—has yet to penetrate much beyond the activists and educators to their constituencies or clients. This transformation of the core message of infection prevention must remain top priority in the foreseeable future for HCV/IDU educators, and the renovation of existing information resources and strategies for information provision must be the first short-term goal of any developmental work in HCV/IDU education.

There are two elements of note in this exercise: first, the correction of inaccurate or inadequate information in formal information provision activities (e.g. revising pamphlets, updating newsletters, etc.)—this is well underway; the second is an engagement with informal information provision systems and processes that compromise prevention messages (wittingly or unwittingly). This second task is more difficult, but key informants gave examples that included the need to tackle an Internet...
awash with inconsistencies and inaccuracies, quirky personal beliefs, individual agendas and out-of-date messages, swamping the small number of under-resourced, more factual and accurate sites of information. There is an opportunity for a significant (and urgent) Australian prevention intervention here.

R6. We recommend the enhancement by the Commonwealth Department of Health and Aged Care of its hepatitis C Website, one that not only provides guaranteed accuracy in its information, but which also actively intervenes in discussions and debates on the Internet to ensure that informal channels of information are monitored, linked and, if necessary, challenged.

The issue here is one of veracity and user confidence in information sought and received. The National Hepatitis C Manual project (see the recommendation 10 below) could provide the actual content for enhancing the Website.

Mode of delivery

The mode of delivery of information is an issue requiring further evaluation research. The survey revealed a wide range of activities undertaken by agencies to disseminate information, but it is noticeable how reliant the sector is on print (86.6% of agencies used pamphlets, 32.8% used newsletters). No doubt these are important resources and, in particular, NUAA’s Users’ News was highly regarded by the field.

In the absence of client-based research (which is outside the brief of this project), however, it is unclear how appropriate such a reliance on print is. Given the range of audiences nominated by agencies in the survey and the heterogeneity of users (even if they were the client category nominated by 68.2% of agencies), this suggests that the predominance of print-based approaches may need to be re-assessed.

R7. We recommend two short research projects using rapid assessment techniques to (1) evaluate print suitability and usage among identified cohorts of users using existing print materials and (2) investigate potential usage of alternative and interactive media, such as the Internet, video and other electronic technology more suitable to particular subcultures of users.

The selection of mode of delivery of any education should be related to the educational moment and the kinds of interactions possible between users and user educators. Issues of client assessment are important here: literacy is definitely an issue when print is involved. So is ways of using, particularly when using is contextualised in particular scenes, such as rave or dance parties. In such cases, over and above equipment provision, electronic interventions may be more useful than print or face-to-face or telephone counselling. Portable disposal units carried by outreach workers may be more effective in street using scenes than a newsletter in certain circumstances.
Key educational program elements

Mode of delivery should be the last decision to be made in designing an educational intervention. Choosing the aim of the intervention, its target audience, its location and siting, its purposes and outcomes, the information component, the human resources input, and the duration: all these come first before deciding which mode (pamphlet, poster, radio advertisement, outreach, counselling technique, video loop, signage, etc.) is employed. This suggests educators need support in developing better program design techniques for education activities, ones that allow educational planning to proceed to mode of delivery rather than from it.

There are five key elements to designing an educational intervention: (1) client and needs assessment; (2) planning and design phase; (3) development and delivery phase; (4) client re-assessment; and (5) program evaluation.

- **Client and needs assessments** are important for clarifying and determining the appropriate target audience and ensuring that its needs (not the educator’s assumptions about those needs) are being addressed.

- The **planning and design phase** is important to forestall a too-rapid move to intervention before all the thinking is done, and involves the writing of a full intervention plan, with educational aims, behavioural objectives, nominated outcomes, evaluation processes, curriculum parameters and style of pedagogy outlined.

- The **development and delivery phase** is where the intervention is piloted and put into practice (along with its appropriate evaluation tools—see below).

- **Client re-assessment** involves various mechanisms to see if the program is achieving its nominated outcomes among the clients, whether in behaviour change, improved information levels, increased agency participation, or whatever has been defined as important in the original client assessment and planning of program aims.

- Finally, the **program evaluation** assesses the success of the program (not the clients) matched against its planned educational aims. (This is the difference between assessing **behavioural** and **educational** outcomes.) Monitoring techniques (the collection of information for evaluation purposes) will have been determined during the design and planning phase and operate throughout the program—not simply undertaken retrospectively at the end. In other words, the argument here is for a combination of **formative** and **summative** evaluation, both planned in advance to ensure good information retrieval.

These elements already happen (albeit, often informally) in many an educator’s planning without such specific delineation, but together they ensure that all ‘stops are covered’ in educational work.
R8. The encouragement of a more systematic style of educational program design and development in the sector will be well served by establishing a portable short course on program design as part of the national training agenda. It is recommended that this be a **practice-based** course, i.e. working with educators *in situ* on real programs, rather than taught in abstract.

**Outreach**

‘Outreach’ was another of those rarely defined terms widely used to describe everything from a mobile NSP to street-working by educators in using sites. The pedagogy of outreach seems to draw most on the skills and experience of the educators themselves (particularly as users or ex-users) and on the vagaries of peer education. This may indeed be the site of some of the best peer education being done at present—it is difficult to tell. But with the increasing shift from home- and network-based using and initiation to street-based using (noted by many key stakeholders), outreach in all its forms is going to become more important. The implication of this shift particularly on initiation, user network formation, mutual care in safer using, the infrastructure capacity for safety in using, and in mentoring drug use, is causing some alarm among key stakeholders and provides a powerful argument for the utilisation of safer injecting sites. But even if safer injecting sites were to open soon, outreach will remain important.

R9. We, therefore, recommend an **outreach development project**, run as a demonstration project to be undertaken along action research lines, which will document and develop outreach as a specific HCV/IDU pedagogy.

This project may best be placed in Sydney, but we would also recommend other sites in a smaller city (e.g. Perth or Darwin) and a region (e.g. the Sunshine Coast) to ensure that lessons learned (triangulated from three sites) are not dominated by the particular nature of the Sydney using scene and are therefore generalisable to other cities and towns.

### 6.4.2 Curriculum development

These elements of the educative moment form the first step toward understanding what is involved in the development of a national hepatitis C curriculum. A step toward this curriculum is already in train in the AIVL project, the National Education/Prevention Program for People Who Use Intravenous Drugs, but this project concentrates mostly on the information aspects of the curriculum, i.e. the content. It is less concerned consciously and directly with educational *strategies* employed, e.g. mode of delivery, or with the pedagogy of the educators delivering the information. Curriculum is more than content. It also includes mode of delivery of education and learning objectives for the clients. For example, the curriculum of the TRIBES project ‘The Game’ not only included HCV prevention education, but life skills, group dynamics and processes, materials production skills, and educational
program delivery and evaluation. The project worker noted that they had achieved something important for the young ‘tribe’ members/peer educators even if ‘The Game’ itself was never completed.

To provide a focus on these aspects of curriculum, there needs to be an ongoing and systematic accumulation of knowledge of the activities of current educators and the strategies they are developing. This is best achieved by a ‘clearing-house’ function based in AIVL, facilitating the ongoing sharing of educational ideas—as well as resources and information—as part of a national curriculum development agenda. This vital activity should initiated as soon as possible and might well copy the success of the British National AIDS Manual project. Such a National Hepatitis C Manual will provide user educators with a single, standardised, accessible reference tool with a regular up-date process to ensure all agencies in HCV/IDU prevention education (and elsewhere in HCV education, counselling, care, and support) are confident of their knowledge base.

R10. We recommend the establishment of an HCV Education Clearing House (HECH) project, whose activities include the development of a National Hepatitis C Manual.

In line with Lowe and Cotton (1999:146) and their recommendation that a core service structure is needed in HCV prevention education, we see an urgent need for a set of activities for Commonwealth or State and Territory consideration designed to accelerate that process of accumulation and to deliver its wisdom to HCV/IDU educators in a manner suited to their needs and work situations.

R11. To achieve this, we recommend that the HECH should be sited within an HCV Education Curriculum Development Unit (HECDU), established for a three-year period and based in the national HCV/IDU agencies, which will outline the core curriculum in HCV/IDU prevention education and undertake a series of activities detailed in a number of subsequent recommendations from this report.

That process would be similar, for example, to the ways in which Education Departments develop sex or drug education curricula. The core curriculum would not just encompass the package of education needed for HCV transmission prevention among users. It would also recognise the larger health education agenda for users in which HCV prevention needs to occur and develop appropriate modes of delivery for that core curriculum in various settings. Therefore, it is envisaged that HECDU would focus not only on HCV education for users but also would take advantage of the common elements in all forms of hepatitis C education. Also HECDU’s work would also provide a common platform for the national training agenda for hepatitis C educators (see recommendation 1). We estimate that a three-year period would be needed to establish HECDU and complete its tasks.

Secondary elements important to a hepatitis C curriculum

There are other elements in the disagreement about the contribution of drug injection experience to good pedagogy, i.e. whether in and of itself that experience is sufficient
to make a good educator or to ground good educational practice. Many respondents were less than complimentary about poor educators in the sector. These were seen to have two major deficits. First, they were unable to rise above their own experience and that of their social network to understand the possibly different situations of clients, to listen carefully to those clients, and to respond to those experiences and needs. Second, they were unable to ‘hold their own’ in various meetings with other health workers, particularly the medical profession, policy makers and researchers.

The first criticism rests largely on the recognition that users are difficult to recruit into programs and activities and lack a deep sense of communality. This requires a particularly sensitive approach by health workers and a capacity to read beyond the immediate and expressed drug-using issue to the full context of clients’ lives. Technically, this might be called a ‘client assessment’ capacity. Many times the key informants expressed concerns about the lacks of skills and training in the sector and, more importantly, the dearth of useful tools (both formal and informal) to undertake client assessment appropriate to the agencies’ programs. By this, we do not mean batteries of psychosocial tests or banks of detailed questions in questionnaires. Rather, there is a need to develop simple, efficient, client assessment tools that work on the ground without disturbing the fragile interaction between educator and client, yet which improve the educators’ judgement of the educational needs at hand and assuring users that their expressed need are heard through:

a dialogue process that...engages people so they have the opportunity to articulate, and have a role in meeting, their own needs rather than, kind of, um, having needs assumed.

The action research points yet again to the value of growing your own assessment tools suitable to each agency and matched to its programs and educators’ skills. The example of that educator re-framing the VDHS questionnaire at WRAP to extend the interaction with the clients and to obtain a clearer picture of risk-taking behaviour and specific ways of using is an excellent example of inventive client assessment. Local circumstances and populations served by specific agencies do require different skills and client-assessment strategies. These client assessment skills will also be useful to determine appropriate treatment options of those users seeking such assistance.

| R12. We recommend that the development of a range of practice-based ‘client assessment tools’ be one important task for HECDU (and also be one of the research aims in the ways of using research project in recommendation 3). |

The second criticism of poor educators with an experience of drug injection actually can be levelled at any health worker—a lack of skills in handling relations with other health workers, especially medical professionals, researchers and public servants is not restricted to drug users. However, this issue points to important activities that user educators undertake (not just in HCV work)—and are expected to undertake in the current policy settings—of advocacy and participation in education for health professionals, as technical resources and as ‘experts’.

Some educators are better at this than others and some agencies specialise in this kind of education for health professionals, seeing their core business as facilitating other
agencies in the public and non-governmental sectors in gearing up for HCV/IDU issues. The issue of advocacy is beyond the brief of this project but it is clear that, in practical terms, agencies working with users are asked very regularly—and expected as a matter of common practice by government, the public and private sectors, and in the non-governmental sector—to participate in events, advocacy processes and consultative activity. There is an inconsistency, then, between what is asked of user educators and what they are funded to do. This inconsistency has resource implications for the agencies (e.g. time lost from projects and from face-to-face work with clients) and is not the best way to ensure that education for health professionals is systematically well done.

In relation to education for health professionals, the health sector as a whole does appear to benefit from these user educators taking part (parallels can be drawn with the effectiveness of gay educators in HIV/AIDS undertaking similar activity). However, as the user educators themselves note, the question of quality and skill remains. This issue would be partly clarified by policy adjustments that delineate and define the part played by user educators and their agencies in education for health professionals, but this must also be pursued along with a systematic training and evaluation program that fits such educators better for their work. There are skilled educators of other health professionals in the sector. Their use and activities require better policy steering and more focused program support.

R13. We recommend a short HCV/IDU project determining appropriate education programs for health professionals to (a) identify the key elements of those education programs to be provided by user educators, (b) develop a short course for training user educators to provide education programs for health professionals, and (c) provide accreditation to user educators trained to provide such education.

This will ensure that user educators participating in education for health professionals will be properly resourced and supported in that work. This issue of resources needs to be included as an item to be investigated in the national benchmarking project recommended above.

### 6.4.3 Encouraging educational innovation

HCV/IDU educators are developing new strategies all the time and, given the unevenness in the sector in training and the differences in agency size and experience, there is a need for special educational support, particularly in the community sector. Unlike the AIDS Councils, it is unlikely that user groups or other community-sector agencies in HCV/IDU work will grow large and be able to develop education teams of any size (this may not be so true for some public-sector agencies). In order to gain maximum benefit from curriculum developments made in the field, documented in the HECH, there is need for a small support team of specialist educators (staffed by experienced educators in the fields, seconded for blocks of time) funded to work with educators to develop their educational activities systematically and professionally.
R14. We recommend the establishment of a three-year HCV Education and Information Support Team (HEIST), as the core staff of HECDU, to work with educators and agencies on requests to, for example, develop new client assessment tools, renovate existing projects, improve resource production, plan formative evaluation to improve programs, encourage reflexive practice activity, and work alongside the agency educators for a period in a targeted or focused pedagogy development activity.

R15. To support this work, and in addition to HEIST salaries and associated administration costs, it is recommended that an HCV Education Innovation Resources (HEIR) fund be established to foster small modelling or pilot projects that might be used throughout the sector.

Eligible agencies would submit proposals for HEIR funds to provide small-scale resources to accompany assistance obtained from HEIST staff to develop new innovative approaches, renovate existing programs and materials, or establish reflexive practice procedures (see below) with HEIST guidance. The HEIR fund will encourage the development of locally specific resources, geared to localised ways of using, e.g. suitable to local forms of injection initiation or local drug preferences, and enable pilot and modelling projects to be pursued.

The key element of this recommendation is that there is no purpose in dis-engaging these two processes: that of producing an HCV/IDU curriculum and of improving the pedagogy of HCV/IDU educators at the same time. They are interdependent components of developing better practice in HCV/IDU prevention education, as they are in HIV education and will be in education for people with hepatitis C. The *educational* underpinnings are very similar even if the viruses, the diseases they cause and the populations they affect are quite different. The purpose of these recommendations then is to achieve a balance between improving the educational activities provided by educators (their style, accuracy, suitability and effectiveness) and simultaneously strengthening the workforce that designs and delivers them.

### 6.5 Community

[Users] come in all sizes and colours, and they don’t have that shared identity or culture, unlike the gay community...[they] have one thing in common and that they don’t talk about very much.

Perhaps the most confused issue that affects the sector is the idea and content of the notion of ‘community’. There are widely acknowledged problems in defining the community for HCV/IDU prevention education. While using provides the locus for any potential collectivity, the only significant link for all its members is a covert and illegal activity that they generally do not talk about. Indeed, apart from using, users may not have any other thing in common with one another. Using as a personal practice might better be understood as contextualised within a larger multifaceted global industry.
The IDU community is a business related through obtaining drugs, money and fits...[a] false creature...it’s happened out of sheer necessity.

However, many interviewees readily used the term ‘community’ in relation to users, and most of the time there was little sense of, or insistence upon, a substantive communality underpinning that usage. In other words, quite often the term ‘community’ was short-hand for users, groups of clients, an agency’s clientele, an advocate’s constituency, or just ‘us’ here in the community sector (i.e. anyone other than government).

This is even more pronounced in relation to an idea of a community of people with hepatitis C, although in many ways people with hepatitis C were thought to have more in common than any idea of a user community. Developing a single and shared sense of community in relation to hepatitis C by all groups affected by it was regarded as unlikely, particularly as many people with hepatitis C do not want to be aligned with IDU and identified with/as users.

One aspect of this is that agencies in the hepatitis C field have different clienteles, each differently structured as a collectivity. Some of them might even actually operate as a deeply structured community (Dowsett 1996), i.e. have a genuine and shared sense of being a group cohering on a number of levels—common history, interests, concerns, language, culture and objectives, and so on. But other agencies, or in each agency at different times, the clientele may have little in common and are largely individuals with no wish or need for ‘community’, particularly in relation to their using. This is particularly the case among some ‘functional users’ for whom there are no ‘peers’ available and no shared sense of communality (Sharp et al. 1991).

The idea of community development offers very different potential for a deeply structured community than it does for clusters of people thrown or finding themselves together by circumstance or a single interest. Yet, this term was often mentioned as if it was of a singular order and commonly understood. Indeed, 50.7% of agencies listed ‘community development’ as one of the hepatitis C services they offered. It is also clear that some activities undertaken under the rubric of community development do work very well and are keyed into the concept well. The TRIBES program and NUAA’s Users News were singled out in this regard for their recognition, in the former, of the subcultural underpinnings of users’ networks, and, in the latter, of the importance of the sense of ‘ownership’ generated by the centrality of users’ contributions to the magazine’s content. WRAP also found their user-contributed newsletter similarly effective. So there is a communality among users available to be worked with. Its shape and character is what is debated.

There’s neighbourhoods of drug users. There’s groups of drug users. There’s scenes of drug users. Sometimes there’s crossovers and that may be geographical location or central scoring location. So there’s a diverse community of [drug users], but not is a broad [conventional] sense.

‘Community’ is, clearly, an ambiguous term in relation to users. However, there are ‘networks’ or local clusters of users sometimes linked by ways of using, sometimes by geography, sometimes by age or generation, sometimes by common circumstances
The bonds within these social networks will vary—from weak to strong, from transitory to longstanding—but each of these networks offers something upon which aspects of the notion of community development might work to foster a collective sense of ensuring safer using. This is more readily available where there is an existing sense of community emanating from other things shared in common (e.g. gay men who inject, or particular CALDB users). Understanding how these social networks operate and are held together is not well-served by some acritical and simplistic employment of the idea of ‘community’.

Rather, notions assessing any social network’s ways of using and its relation to other structuring dynamics (e.g. age, location, subculture, sexuality, music scene, etc.) will produce a more sophisticated understanding of where using sits within the social relations of any group of users, what specific meanings it makes for group members, and what subcultural resources are available in those social relations for educational use (e.g. specific languages, places for outreach, issues of literacy). Networks were often seen as more suitable sites of education by some key stakeholders, particularly when users were small sub-groups of other communities such as gay men, but an understanding of the structural dynamics of social networks where such observable identifiers are absent was less in evidence.

It must also be recognised that there is a continual need for re-assessing any targeting of social networks, because these networks break down and re-form with different and shifting patterns of drug use, as was noted often in relation to the recent shift from home-based using to street-based using. This emerging problem highlights one central feature of community development noted by some experienced educators: the importance of connecting networks of users to health resources, services and programs already available, and increasing users’ confidence that they are, as citizens, entitled to use such services and claim support from public health system. In this last regard, issues of discrimination and stigmatisation remain ones nominated by key stakeholders and in the initial consultations as important areas for education and advocacy.

Clearly, there needs to be some clarification of the concept of community development in relation to HCV/IDU prevention education, as its potential will vary greatly among different users and in different places and agencies.

R16. We recommend a ‘community development’ modelling project be established in HECDU to provide specific support for the sector in determining practices, processes and evaluative techniques to be used in community development aspects of HCV education.
6.6 What is successful education?

Most educators had only limited opportunities to reflect on their practice and welcomed the opportunity given them by this project—an example of how research is more than investigation and documentation but can also serve as an intervention in a field as well:

I think that, for me, it can only serve to clarify where we need [and] what we need to be doing on the ground, you know. Because I think that those types of reflective opportunities give you a chance to go: ‘Okay, what were we trying to achieve with this right back in the beginning? And, you know, what...made us think about this is the first place? And, then, how did we try and meet that? And it didn’t work. Why didn’t it work?’

A lack of time to reflect was particularly the case when it came to assessing the effectiveness of education programs. However, the Activity Questionnaire revealed an impressive array of evaluation tools in the sector (see Table 10). Clearly, HCV/IDU educators are concerned with the quality and effectiveness of the programs.

Yet, key stakeholders thought that there has been a significant lack of good evaluation of programs in this field, particularly in ways which involved educators themselves in the evaluation for the purpose of program improvement and development. Counting and recording numbers was almost universally practised (if with varying frequency, and particularly in the NSPs), but was seen to be geared largely toward funders’ needs rather than focused on assessing the effectiveness of education.

There is no doubt that counting (people, events, ‘fits’, pamphlets) provides a measure of activity, and that in itself is very useful in this sector where, as one educator noted, just getting users through the door is a small win—getting a lot of them is a victory. It is also clear that educators know that more than counting is needed: as the analysis of education and evaluation activities revealed, there is some evidence of educators (and agencies) choosing evaluation techniques to suit certain types of educational interventions. Yet these associations were not strong and suggest that there is a need to develop and enhance the use of evaluation techniques better matched to the educational imperative of any intervention, not just for funding accountability. This is ultimately in the interests of all (including funders) for, particularly in relation to ongoing programs in the context of tight funding, evidence of improvement and effectiveness is as important as accountability.

Often forms of ‘shallow’ evaluation that were currently practised did not always engage the detail of educational processes. A distinction must be made between information/knowledge transfer and real education—an interaction or a process that generates an educational outcome. This distinction is critical in an area where the educational opportunities are short and limited. For example, a momentary opportunity may occur at the point of equipment provision and the transient nature of some users means that educators do not always and often get a second chance. As revealed in the action research, good educators can often turn a brief interaction into a
more protracted, dialogic educational moment. Clarity about what constitutes successful education under these circumstances would be very helpful in training future educators, and it is evaluation focused on pedagogy that produces this clarity.

R17. To encourage better evaluation processes (in addition to the initiatives in the program design recommendation above), we recommend establishing a two-year evaluation matching project, based in HECDU, one which fosters a more selective use of evaluative techniques better matched to the educational aims and behavioural objectives of a given intervention.

6.7 Encouraging reflexive practice

I never do that because I just don’t have the time. And the things—thinking about what went wrong, that’s usually when you’re lying in bed at night going: ‘Ah, shit! Did I really do that? What am I going to do tomorrow to make it better?’ That kind of stuff. And that’s possibly the nature of the work we do. There’s very little time for reflection.

The best form of evaluation for educational purposes lies in developing processes of reflexive practice as part and parcel of the daily business of HCV/IDU agencies. There is rarely sufficient time of educators to reflect critically on their work. By ‘critical’ reflection we mean an approach that subjects educators’ daily activities and ideas to questioning by the educators themselves in formal and informal ways so that those activities and ideas are constantly re-assessed for their underpinnings and assumptions, and monitored for their effectiveness and appropriateness. This ongoing reflection then engages a process of enacting decisions and re-aligning the program in response. This cycle of reflection and enacting is reflexive, i.e mutually constitutive, and is called reflexive practice.

As the action research revealed, educators do use a range of reflection techniques, both formal and informal, individual and collective: from incident books (formal/individual) and planning days (formal/collective) to thinking in the car (informal/individual) and chats with colleagues over coffee (informal/collective). These are sometimes peer education events as well, as revealed in the TRIBES project participating in the action research, where the young participants involved were learning about hepatitis C and educating others in turn at the same time. Reflection happens in all agencies:

We talk about things like that constantly. That’s how we support each other, that’s how we inform our practices...we have meetings with the constituents. And the rest of the time, whenever we are together we try and get a staff meeting together. Sometimes we’ve had meetings to plan a strategy, to evaluate what we’ve done—some things like that—but mostly of it would be done on ambit [general] basis.

Effectively utilising and enhancing these techniques of reflection is a vital educational labour process issue—i.e. it is about understanding the innate way educators do their work, how they think and plan, what experiences they use, what ideas influence them,
and how these together make up the key intellectual and psychological aspect of educating as a job, a craft, a profession. It is also about managing an educator’s day so that there is time for reflection and for harvesting the benefits from it. Even without support, good educators almost intuitively reflect—they cannot help it:

I would, like, say: ‘Oh God! That was a shocker’, or be quite aware of when you’ve had a shocker, when you know that you’ve just, like, alienated the person that you’ve been speaking to and you scared them—that kind of stuff. And, I mean, that’s always so subjective as well. It’s, like, you know, on any given day, my self-esteem will be between one point and ten points!

In developing this capacity and harnessing it to better practice, collegiality is a key strategic resource. Creating time for critical reflection, particularly collective reflection whether in staff meetings, national workshops, through documentation, debate, or engagement with theory, and planning programs to make space in the educators’ day for critical reflection time and activities are central to developing culture of reflexive practice in HCV/IDU agencies. This is currently lacking according to key stakeholders and its establishment and resourcing will be necessary to obtain better practice in the sector. Many mechanisms can achieve this.

R18. We recommend that funding agencies be encouraged to allocate 10% of funding to any program or project in future to develop reflexive practice (not just but including evaluation) in that program or project.

Some of the techniques employed in the action research will be useful here, particularly the ‘Grid Exercise’. Also, there is much to learn from the detail of the three action research projects reported in Appendix 5.

6.8 Other work force issues

Key stakeholders spoke of the high turnover of staff, the frequent rates of ‘burn-out’ and the lack of professional career support and recognition given to educators, especially those in small agencies. Larger agencies were able to offer more internal supports. Educators frequently worried about doing a good job and about incidents where they felt they had performed less well. Smaller States and Territories and communities were struggling without enough support to maintain a harm reduction approach in the face of what were called ‘get-tough’ policies by various governments.

We believe that our recommendations go some of the way to overcoming these problems by creating a national HECDU whose work will operate mostly locally. It is also becoming important to provide more coordinated local support, particularly where the delineation of roles for the Hepatitis C Councils and Users Groups are not clear (they were causing trouble almost everywhere according to informants in the initial consultations), and in States and Territories where the actual number of HCV/IDU activities on the ground (and the number of educators providing them) is quite small. There is a need to build interagency support structures where needed to
maximise efficiency and cooperation between local agencies in the sector and to
enhance reflexive practice among user educators, particularly those working alone in
their agency.

R19. We recommend that funding be provided to support the establishment and use of
a hepatitis C interagency model on local levels, particularly focused on education
whether for prevention or health maintenance and treatments purposes.

Agencies already involved in hepatitis C work such as haemophilia associations and
local HIV/AIDS agencies should also be involved, as the educational issues are very
similar, particularly in community-based education, even if the conditions, illnesses,
viruses and/or infections are different.

It will be particularly important to include the NSPs in this as they are a key frontline
prevention activity. Many NSP workers want to improve the educational activity
levels of their services, even in the face of severely truncated interactions with clients
and their staffing and resources shortages. Maximising the educational activity levels
of NSPs is one very important step to improve the overall level of education provided
to users and to ensure better educational practice in the sector.

R20. We recommend the funding of a NSP-based HCV/IDU prevention education
development project to work specifically on developing practice-based strategies for
enhancing educational activities in NSPs nationally.

Finally, a number of key stakeholders mentioned the importance of pharmacies as key
points of contact with users. As such, there is yet another possibility for educational
materials and activities to be developed where and as appropriate in conjunction with
Pharmacists Guilds and allied associations.

R21. We recommend the Commonwealth Department of Health and Aged Care
initiate the collaborative development of a Pharmacy Hepatitis C Education Project, to
complement any existing training available to pharmacists, with a view to producing
enhanced educational strategies targeted at users and suitable to pharmacy-based
delivery and circumstances.

6.9 Research

This research project was difficult to undertake at times because the sector is not
unified, nor has it a long experience of social research, unlike parts of the HIV/AIDS
sector. And we must report that, while a number of individual researchers were singled
out for praise from educators in relation to their long service, dedication and
commitment to users and HIV and HCV issues, the sector’s overall experience of
research has not been uniformly happy. Yet, there is a real thirst for research
knowledge and information, particularly social research, and a real willingness to
participate as long as educators are consulted properly and able to participate in the development of research agendas.

Lowe and Cotton (1999:151ff) noted the need for both investigator-led and directed HCV research, as well as the need for community-sector involvement and the importance of social research. We would add educational research to that. We certainly recommend that further research and evaluation be undertaken to define the nature of what constitutes successful education for users and that experienced educators themselves be involved in such a process. We would argue that local issues deserve a place on the national research agenda, as some State and Territory Governments do not fund research. There is a need for better understanding of local IDU issues, e.g. local ways of using. We hesitate to nominate any definitive research agenda, however, as we believe that it must be consultatively developed within the sector.

R22. We recommend as a starting point a brief national consultative project that collects a draft research agenda for circulation and discussion, and that this forms the basis of submission to whatever research coordination development mechanism is outlined in the forthcoming National Hepatitis C Strategy.

Finally, we would urge the expanded use in hepatitis C education of the ‘research-into-practice/practice-into-research’, ‘researcher/community liaison’ and ‘research dissemination’ activities developed in the HIV/AIDS field. The diverse nature of the sector means that many different types of research approach are needed but, where possible, collaborative and practice-driven research is more likely to have a more immediate effect and to produce better educational and evaluation practice in this sector.


Stimson, G.V. & Rhodes, T. (1997). Comments on Hulse’s ‘Australia’s public health response to HIV and HCV: a role for “affected” communities’: conditions for the


APPENDIX 1

ADVISORY COMMITTEE TERMS OF REFERENCE

1. The Advisory Committee offers support and advice to the Principal Investigator and the research team by:
   • providing advice and ideas in relation to the project’s aims and purposes;
   • assisting in defining the parameters of the HCV/IDU sector;
   • providing assistance and support in accessing organisations relevant to the research project;
   • helping develop a profile of key stakeholders in the sector;
   • offering individual assistance based on members’ areas of expertise on methodology, sampling, and/or research processes during the life of the project.

2. The Advisory Committee will review the progress of the project regularly in relation to the research plan at three meetings to be held at: (1) commencement of project, (2) mid-way through the field work, and (3) before completion.

3. The Advisory Committee will appraise the draft final report and its recommendations before its submission to the Commonwealth.
APPENDIX 2

FACE-TO-FACE CONSULTATIONS

Australian Capital Territory 3/9/98

AIVL/CIN
Jennie Siddins (Project Worker)
Jude Byrne (AIVL Coordinator)
Tarquin McPartlan (CIN Educator)

Australian Hepatitis Council (AHC)
Jack Wallace (Executive Officer)

Health Strategies Devt. Unit, ACT Dept. of Health
Simon Rosenberg (Manager)
Fran Barry (Policy Officer)

Mike Kennedy (Exec. Officer, AIDS Action Council)

New South Wales 4/9/98

ACON
Dr David McInnes (Lecturer/Researcher)
Brett Allen (Education Manager)

ANCARD
Ronald Govers (Project Officer)

NUAA
All staff, except Fiona Poeder (TRIBES manager)
Annie Madden (Coordinator)

NSW Health
Owen Westacott (Acting Manager, HIV/AIDS and HCV)
Rhia Maximillian (Evaluation Officer, HCV Dem. Projects)

Tasmania 8/9/98

Department of Community & Health Services
Neil Cremasco (Clinical Nurse, Communicable Diseases Surveillance)
Sexual Health Program, DCHS
Peter Lucas (Coordinator, Tasmanian NSP)
Vicki Savvage (Educator/Researcher, Drug and Alcohol Service, Hobart)

TUHSL
Stewart Williams (Coordinator)

TASCARD
Mel Tonks (IDU Educator, HepC Council President)

Western Australia 10/9/98

WAAC
Frank Farmer (Acting Community Education Manager)

WASUA
Tamara Speed (Coordinator)

WA Health
Dr Lewis Marshall (Manager, Communicable Disease Control Program)
Jude Bevan (Policy Officer, CDCP)

Curtin University of Technology
Wendy Loxley (National Centre for Research into the Prevention of Drug Abuse)
Susan Carruthers (PhD candidate, HCV/IDU researcher)
South Australia 11/9/98

Drug and Alcohol Services Council (DASC)
Bob Braithwaite (Manager, Communicable Diseases)
Dr David Shaw (GP with high HCV caseload)

South Australian Health Commission
Kirsty Hammett (Coordinator, HCV Program)

SAVIVE
Damon Brogan (Coordinator)
VJ Thorpe (Private Mobile NSEP) 16.00-17.00

Northern Territory 21-22/09/98

Danila Dilba Aboriginal Health Service
Louise Brown (Coordinator)
Darryl Thomas (Educator)

AIDS/STD Unit, Territory Health Services
Naomi Oliver (Project Officer)

HepC Support Group
Kris Holden (Coordinator)

NTAC
Barry Horwood (Executive Director)

HINT
Alex Thistlewaite (Educator)

NT Dept. of Correctional Services
Stewart LaBrooy (Project Officer, Health Services)
Wendy Hunter (Education Manager, Health Services)
Victoria - September/October 1998

VIVAIDS
All staff

Victorian Aboriginal Health Service
Terry Lehmann (Sexual Health Educator)

VAC/GMHC
Peter Perfrement (Gay/IDU Educator)

Western Region AIDS & Hepatitis Prevention
All staff

Hepatitis C Council of Victoria
Jill Meade (Coordinator)
Carlo Campora (Educator)

St Kilda Crisis Centre
Simon Kroes (Coordinator)

Turning Point Drug and Alcohol Centre
Craig Fry (IDU Researcher)
Greg Rumbold (IDU Researcher)
Andrea Grinrod (Clinical Nurse Educator)

McFarlane Burnett Centre
Dr Nick Crofts (Deputy Director)

Melbourne Inner City Needle Exchange
Craig Mercer (Manager)

Queensland 09/11/98

Brisbane Youth Service
Anna Patterson (NSEP worker)

QUIVAA
All staff
Telephone Consultations

Queensland

Jeff Ward (Hep C Council Coordinator) 09/09/98
Stephen Gallagher (QuAC Education Manager) 12/09/98
Alex Wightman (QUIVAA Coordinator) 17/09/98
Dianne Flint (GAIN IDU Educator) 22/09/98
Kerry Mason (SCIVAA HCV Educator) 19/10/98
Rosemary Larkin (GAIN Coordinator) 19/10/98
Jessie Gilbert (YouthLink, Cairns) 29/10/98
Anna Patterson (Brisbane Youth Service) 29/10/98

Victoria

Michael Batchelor (STD/BBV Prog., Victorian DHS) 14/09/98
Belinda Mawby (Drugs Action Team, Melb. City Council) 21/09/98
Cheryl Delalande (Manager, North Eastern AIDS Prev.) 14/10/98
Craig Mercer (ANEX) 15/10/98

Northern Territory

Merren Hare (Menzies School of Public Health) 15/09/98
Sue Fielding (ACOCA NSEP - Alice Springs) 29/09/98

Western Australia

Mark Bebbington (WAAC Education Manager) 31/08/98
Colleen Knight (Perth Aboriginal Health Service) 20/10/98

South Australia

Dr R. Creaser (GP/educator in prisons) 01/09/98
Deb Thiele (HIV/AIDS/HCV Coordinator, Multicultural) 02/09/98

Australian Capital Territory

Dr Gabrielle Bammer (ANU) 21/09/98

New South Wales

Tony Hand (ACON) 09/09/98
Fiona Peddar (TRIBES Manager) 21/09/98
Steven Hall (RANZCGP) 17/09/98
Jan Cregan (Macquarie University) 07/10/98
Larry Pierce (Manly D&A Service) 15/10/98
Rodney Watson (S.Sydney AHS) 26/10/98

Tasmania

Peter Lucas (Sexual Health) 01/09/98
### APPENDIX 3

#### CODING SYSTEM FOR QUESTIONNAIRES

<table>
<thead>
<tr>
<th>AGENCY TYPE</th>
<th>NUMBER SENT TO EACH AGENCY</th>
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<tbody>
<tr>
<td>A USER GROUPS</td>
<td>10</td>
</tr>
<tr>
<td>B PRIMARY EXCHANGES</td>
<td>4</td>
</tr>
<tr>
<td>C AIDS COUNCILS</td>
<td>3</td>
</tr>
<tr>
<td>D PLWHA ORGANISATIONS</td>
<td>2</td>
</tr>
<tr>
<td>E REGIONAL HEALTH CO-ORDINATORS</td>
<td>3</td>
</tr>
<tr>
<td>F HAEMOPHILIA ORGANISATIONS</td>
<td>2</td>
</tr>
<tr>
<td>G CORRECTIONAL SERVICES</td>
<td>3-10</td>
</tr>
<tr>
<td>H DRUG &amp; ALCOHOL</td>
<td>3</td>
</tr>
<tr>
<td>I HEP C COUNCILS</td>
<td>3</td>
</tr>
<tr>
<td>J SEX WORKER GROUPS</td>
<td>2</td>
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<tr>
<td>K OTHER</td>
<td>X</td>
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</tbody>
</table>

* Numbers sent out varied according to size of organisation as determined in discussion with agency.
## APPENDIX 4

### THEMES FOR KEY STAKEHOLDER INTERVIEWS

**Module 1: NGO agency-based stakeholders**

<table>
<thead>
<tr>
<th>THEME/QUESTION</th>
<th>PROBES</th>
</tr>
</thead>
</table>
| 1. Life history/life Geography | - Short biography  
- What do you bring to this job? |
| 1. Better practice models | - Are risk group-specific services or disease-specific services more effective in HCV prevention education?  
- Efficacy of peer-based versus ‘expert/client’ approaches?  
- What modes of communication are most effective? (group, newsletter, face-to-face, etc.)  
- What defines a ‘good’ peer educator?  
- What defines a ‘bad’ peer educator? |
| 3. Barriers and impediments to better practice | - What are the key political/legal constraints affecting the delivery of effective HCV prevention education?  
- Are there other socio-cultural factors impinging on the delivery of this education? |
| 4. Perceptions of community | - Is there a HCV community?  
- Is there an IDU community? How salient are community development strategies? |
| 5. Techniques for evaluation/ performance indicators | - How do you gauge performance?  
- Your own performance?  
- Do you utilise outside assistance/consultants? |
| 6. Role of HCV-positive people in prevention education | - What can be learnt from the PLWHA model?  
- Will radical activism in the HCV area need to come from HCV+ people themselves? |
| 7. Intra-sectoral approaches | - How prominent is HCV prevention education in the IDU sector?  
- To what extent do agencies focus on user advocacy vs. disease model?  
- Do agencies working with IDU see themselves more as community-based or non government organisations? |
| 8. Community sector inter-relationships | - How is the IDU sector currently positioned within the HIV/AIDS sector?  
- With whom do you form partnerships? |
<table>
<thead>
<tr>
<th>THEME/QUESTION</th>
<th>PROBES</th>
</tr>
</thead>
</table>
| 9. Relationships with other health professionals | - How has mainstreaming affected HCV previous education?  
- Describe the current relationship between IDU sector and other health services? |
| 10. Funding fragility | - How reliant is your agency on fundraising to deliver effective HCV prevention education?  
- Has cost recovery been an issue? |
| 11. State/Territory-specific | - What are the idiosyncratic issues in your State/Territory? |
| 12. Future directions | - Will HCV prevention education continue to be seen as an adjunct to HIV/AIDS prevention education or will it emerge more prominently under another umbrella (e.g. BBV, sexual health, drug and alcohol)?  
- What are the prospects of continuing harm reduction strategies?  
- Any other suggestions for improved HCV prevention education among users? |

**Module 2: public sector-based stakeholders**

Same schedule as above except:
- delete themes directed at ‘funding fragility’, replace with ‘What requirements should funders make of HCV prevention education programs, projects and educators?’

**Module 3: academic-based stakeholders**

Same schedule as above except:
- delete themes directed at ‘funding fragility’, replace with ‘Is there sufficient funding for social and behavioural research in HCV prevention education?’
APPENDIX 5

THE ACTION RESEARCH PROJECTS

A. The ‘WRAP’ needle and syringe program

A.1 Description of the program

Philosophy and aims

Melbourne’s Western Region AIDS Prevention (WRAP) program aims to reduce and prevent the transmission of BBV, particularly HIV and HCV, and STIs among people who inject drugs. Harm minimisation principles underpin WRAP’s philosophy within the overall framework of the National HIV/AIDS and Related Diseases Strategy.

Role and structure

1. To provide a comprehensive NSP service interacting with people who inject drugs primarily to encourage safer drug use to reduce the transmission of BBV.
2. To provide information and referral on a range of health and welfare services, including support and information on drug treatment options.
3. To promote safe needle and syringe disposal and facilitate a collaborative community approach to disposal.
4. To provide a community resource on issues relevant to STI/BBV.
5. In conjunction with the Association of Needle Exchanges and the STI/BBV program of the Victorian Department of Human Services (VDHS), assist with the development and support of secondary NSP outlets in the western metropolitan region of Melbourne, and explore other options to increase access to the means of prevention.
6. To promote cultural awareness on the importance of infection prevention measures for BBV/STI.
7. To secure a stable future for WRAP within Footscray and throughout the western metropolitan region by improving levels of community understanding and acceptance of the program and reducing the number of inappropriate client-related incidents around WRAP.
8. To improve access options to sterile injecting equipment in Footscray by seeking the cooperation of pharmacists on re-establishing the sale of injecting equipment.

While fulfilling these aims, WRAP seeks to become involved in service user projects and activities beyond the NSP itself. For example, WRAP conducts twice daily ‘street sweeps’ within two locations whose perimeters stretch several blocks from the WRAP building to remove discarded needles, syringes and associated injecting debris.
WRAP has operated in Footscray since 1990 and is one of ten primary AIDS prevention programs in Victoria. As the only primary fixed-base NSP located within the VDHS’s western metropolitan region, WRAP identifies as a regional service. WRAP is fully funded by VDHS.

**Project management**

As part of the process to establish WRAP as a fixed outlet in 1996, a Program Advisory Committee was formed. Meeting monthly, the Program Advisory Committee consists of representatives from WRAP, Maribyrnong City Council, the Public Health Unit of the western metropolitan region, the Western Region Health Centre and the VDHS STI/BBV program. WRAP’s Community Liaison Committee operates as a formal avenue of communication between WRAP and members of the community, and is a condition of WRAP’s planning permit.

**Client profile**

Heroin appears to be the drug of choice of the majority of people currently using the WRAP NSP. Most service users are regarded by WRAP staff as responsible people who are interested in protecting the health of themselves and others, and who contribute to the important role of safe disposal.

The western metropolitan region and particularly Footscray are home to well-established communities of people from Southeast Asia, largely from a Vietnamese-speaking background. Since WRAP began, people from this community who inject drugs have increasingly come to the NSP and account for between 10% and 30% of all client contacts, currently 200-300 client contacts per month. WRAP’s client contact has been significantly increasing over the past eighteen months. In the second half of 1997, 13,928 client contacts were reported and this figure had climbed to 16,717 in the first six months of 1998.

**Staffing**

Staff are employed as Community Development Workers, and current staffing levels are: one full-time program manager; three half-time NSP officers; and one half-time education officer (currently a twelve-month project until June 1999).

**A.2 Institutional issues**

**Recruitment of staff**

WRAP has tended to recruit its workers from those with experience working in other NSPs. All WRAP workers have brought some working experience in the IDU field to their jobs. There was little formal education/training provided for WRAP workers—‘on the job’ experience, including some experience of working at other NSP, has significant credibility.
Servicing the community

WRAP relocated to its current premises in Footscray after two years of operation as an outreach service during a time of intense community debate about the role, place and practicalities of a local NSP. Although based in Footscray, staff are authorised to deliver and develop NSP services within the western metropolitan region, and WRAP was directly involved in establishing most of the region’s secondary outlets that are now operational. Due to the strain on existing resources, however, the service is essentially limited to the needs of the immediate Footscray area.

Environment

Like the majority of NSPs, WRAP’s capacity to facilitate educational interactions is clearly shaped by the critical role of the exchange’s physical layout. While this is an issue that WRAP workers are aware of (and most NSPs visited by research staff were in equally physically cramped locations), its effect on WRAP’s work was rarely discussed. WRAP is, however, well located for its primary purpose—at the southern end of a busy commercial street, some 400m from the Barkly Street Mall, the heart of Footscray’s central business district. Several dealing and using ‘hot spots’ are located in close proximity to WRAP, including a sheltered, dimly lit area beneath a large corporate building, a park adjacent to the railway station and an abandoned lawn bowling clubhouse (burnt down in January 1999). With such prolific using close by, WRAP has long had to offer an environment that not only fosters amicable regular client relations but is simultaneously capable of dealing with more volatile clientele about to and/or having just ‘scored’.

A brief sketch of WRAP’s physical layout shows a single-fronted brick dwelling opens to a 5m x 6m front room where the provision of injecting equipment takes place. Two large desks stand diagonally in the back corners of this room and always one but often both have staff sitting ‘in waiting’ for WRAP clients. A two-seater lounge chair backing onto the front windows and a large filing cabinet filled with injecting equipment back-up supplies are the only other items of furniture. Not only is this essential in allowing generous physical space for clients to obtain injecting equipment and still have time to ask questions, it engenders a welcoming atmosphere that other more ‘over-the-counter’ style of NSPs do not.

The relatively generous amount of physical space does seem to enhance face-to-face educational possibilities and there are other options for utilising the available space. More work rooms in the building are accessed through a door in the front room and behind this lies a narrow room that separates the public from the main staff working area. During a previous research project, interviewers were able to spend lengthy periods with clients in this room and reported little difficulty in attracting clients to this voluntary study. But clearly, NSPs have problems in the infrastructure within which they are asked to work as a result of resource constraints and this warrants serious review.

External relations

WRAP staff must be applauded for their ability to engage successfully with the wider community through general community education. This has helped to legitimise the
role of NSPs in the community and enabled the centre to be a ‘safe’ place for users. However, these efforts sometimes hinder a focus on direct education with clients, particularly the extent to which WRAP is forced to manage relations with local traders and professionals. Liaison with police, for example, requires ongoing attention to prevent problems such as police parking their marked vehicles outside WRAP’s front door. The issue of police presence and its constant impact on clients demands WRAP’s active involvement on the Maribyrnong Police Community Consultative Committee.

Within the local area, WRAP enjoys a cordial relationship with other service providers. The strongest link is with a Youth Outreach Team based at Western Hospital, which places one worker at WRAP for a few hours per week addressing young people’s alcohol and other drug issues. WRAP staff reported this as a positive experience and are seeking to increase the team’s time at WRAP.

As a very active member of the thirty-one organisations in Victoria’s Association of Needle Exchanges, WRAP enjoys a reasonably harmonious relationship with other NSPs in the Melbourne metropolitan area. However, this relationship essentially exists between coordinators, and workers have very little exposure to the sorts of educational approaches adopted in other NSPs through the Association’s activities—a possibility exists here for fostering more sharing of educational ideas and resources.

Finally, WRAP receives a large number of callers upset about inappropriately discarded needles and syringes and has developed a sound protocol for dealing with these complaints. Although it can be argued that these external efforts create a more conducive educational environment for the workers and clients, constantly ‘putting out fires’ can detract from the service’s primary focus. WRAP is neither funded nor staffed adequately for this necessary aspect of its work. Yet, these contextual activities are actually central to the success of its equipment provision program and its educational work.

### A.3 Action-research project

#### Methods used

Research staff carried out one-to-one semi-structured interviews as well as informal discussions with all agency staff members, including ‘critical incidents’ story-telling techniques to identify educational practice and pedagogical techniques. These interviews allowed the researchers to document education and prevention strategies, build a picture of IDU issues in the Footscray area, and provide an understanding of the local context and environment in which WRAP operates.

Over the ten-week action-research period, research staff were able to spend over seventy-five hours observing the various practices of WRAP staff members, including attending staff meetings and special project committee meetings. Research staff also reviewed written materials from WRAP, including meeting agendas and minutes, annual reports, funding submissions, special project summaries, NSP statistics, communication logbooks, and position descriptions.
**Education in practice—the ‘Grid Exercise’**

The first of two formal ‘reflexive practice’ exercises conducted with the WRAP staff involved mapping the day-to-day practices of WRAP educators on formal/informal, individual/collective axes (see Table 13 below). To warm up for this exercise, staff were asked to work in pairs and discuss (1) what principal skill they brought to their job at WRAP and (2) what was their most underutilised skill. The first question produced the following responses:

- ability to listen and care;
- looking at the whole person, and recognising diversity;
- personal understanding of using and the ability to draw upon that;
- approachability, having a ‘soft aura’;
- experience-based knowledge/information and the confidence that comes with that.

For question two (the underutilised skills), staff members listed:

- informed knowledge;
- initiating one-to-one interactions, focus group work, special projects;
- listening opportunities with users;
- breaking down community prejudices;
- dealing with in-built dysfunctionality;
- first-hand experience and secondary knowledge;
- differentiating between learning styles—kinaesthetic versus cognitive.

By asking WRAP staff members to reflect on their own abilities, research staff were able to move workers towards a more reflective mode for the ‘Grid Exercise’. Suggestions for each of the four quadrants of the grid were slow to emerge at first, but the process gathered momentum as workers began to speak of their formative educational experiences, not only within the confines of their work at WRAP. All workers reported back to research staff in the following days that the exercise had proven very useful in helping them see themselves as IDU *educators*.

**Table 14: WRAP ‘Grid Exercise’**

<table>
<thead>
<tr>
<th>Formal/individual</th>
<th>Formal/collective</th>
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<tbody>
<tr>
<td>other research</td>
<td>stocking library/media file</td>
</tr>
<tr>
<td>reading info tray, incl. newspapers</td>
<td>street beat</td>
</tr>
<tr>
<td>street sweeps</td>
<td>Vietnamese project inc. Packs (MBC)</td>
</tr>
<tr>
<td>incident book</td>
<td>focus groups</td>
</tr>
<tr>
<td>message books</td>
<td>research findings, esp. acting immediately on outcomes</td>
</tr>
<tr>
<td>Networking</td>
<td></td>
</tr>
<tr>
<td>‘Dragon’s Lair’ Play</td>
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</tr>
</tbody>
</table>
HCV/IDU Prevention Education in Australia

Informal/individual | Informal/collective
--- | ---
weekend chat | coffee
other work | smokers’ chat
Lunchtime ‘bump-ins’ | chatting with colleagues/peers at work
Attending Tet festivals | chit-chat in between formal training sessions
street walking through Footscray | 
Changing attitudes in casual conversations |

Strategic communications—the ‘Sharing Question’ exercise

The staff participated in a ninety-minute exercise to discuss approaches to one of the questions from the mandatory short survey asked of WRAP clients as they receive injecting equipment, administered as part of the NSP evaluation sheet provided by the STI/BBV program in VDHS. The question has two variations: for repeat clients it asks ‘Have you had to share any injecting equipment since your last visit?’; for new clients the question becomes ‘Have you shared any injecting equipment before?’. During informal discussions with all the agency staff, it was thought that this question provided considerable potential for offering direct education to users. All believed that it was important to follow up with a straightforward message about safer using when a client replied ‘Yes’ to either version of the question. However, these moments were extremely rare. In the first six months of 1998, only 0.7% of WRAP clients stated that they had shared any injecting equipment. Though this was the lowest percentage of the four largest Melbourne NSPs (it did not exceed 3.8% in any of them), it suggests that, in most WRAP staff’s opinion, the figure under-represented the extent of sharing. This being the case, the staff agreed to participate in a discussion aimed at facilitating more opportunities for client interaction, including enhancing the potential for clients to admit they had shared injecting equipment.

Initially, the discussion on the question focused on the particular constraints affecting its effective delivery. Most commonly cited was the hurried nature of the interaction and equipment provision, especially where the client was eager to pick up and leave as soon as possible. The ‘sharing’ question is one of six mandatory questions that agency staff ask of clients and, though the ‘sharing’ question was the most important of these, some staff reported that it tended to get ‘buried’ or ‘sandwiched’ between the others. Even when a client has answered ‘yes’ there are difficulties in engaging in any meaningful subsequent discussion if other clients are waiting to be served. More problematic, however, is the difficulty of eliciting a believable response when even the most inexperienced of users has some awareness of the dangers of sharing. As one worker said, ‘It’s like asking “Have you lied recently?”’. Another recalled the words of
a new client when they were asked the sharing question, ‘Does anybody say “yes” to you? Is anybody honest?’.

The majority of WRAP’s clients regularly attend the centre and have developed a ‘rapid bullet’ style of answering the required questions. It was not uncommon for clients to say, ‘Repeat, five, for myself, ten fits, no, four’ in the one breath as they approached the counter; the ‘no’ in answer to the ‘sharing’ question, squeezed in among answers to the other five questions. In this situation, agency staff said it was virtually impossible to double check the veracity of the ‘no’ response.

The importance of how the question is asked was also stressed. Many agency staff reported that the expectation of a ‘no’ response had led them to asking the question hurriedly as ‘And you haven’t shared since you were last here, have you?’, which it was agreed was very unlikely to elicit a ‘yes’ response. Other modes of asking the question were discussed and it was agreed that the question asked as written but with an upward inflection was likely to be more engaging. All thought it was essential to never omit ‘any injecting equipment’ from the question particularly for older users schooled more by the needle and syringe cleaning framework than by the recent education messages stressing blood awareness.

Of interest was the example of another worker who told how she split the question in two, first asking ‘Have you shared any fits?’ and then ‘Have you shared any other injecting equipment?’. She reported that invariably there were more ‘yes’ responses to the latter question. Staff members thought this to be a far more effective way of asking the question and planned, as a consequence of this discussion, to start asking in this manner immediately—a simple, if effective example of the benefits of reflexive practice processes in operation.

Terminology was particularly important in asking the question to users with poor English-language skills, although one worker noted even the difficulties of using specific terminology when, for instance, there is no Vietnamese translation for particular injecting equipment items. Just as important as the words chosen is the tone of the delivery. Staff said that no matter what way the question was asked, it needed to be part of an overall engagement with the clients that was non-judgemental and non-threatening from the moment they walked through the door.

Discussion shifted to strategies employed by agency staff when the answer to the question was ‘yes’. The most common situation staff faced was when someone said they shared injecting equipment over the weekend, because WRAP is only open from Monday to Friday. In these cases, all workers said they tried to encourage users to prepare for their weekend using and to be aware of contact details for their local mobile after-hours NSP.

Other educational opportunities arose following a ‘yes’ response by asking about HCV testing. For more inexperienced users, workers said they had been able to engage in reasonably lengthy dialogues where the user expressed some uncertainty about why they would need such a test. A few other clients spoke about how a recent negative HCV test result for their sharing partner had encouraged a form of ‘sharing blackmail’. It was not unusual for couples to be well-represented among the ‘yes’ respondents. Some cited that their experience and knowledge facilitated safer using
and other younger couples described a feeling of ‘safety’ in sharing together. In either
case, workers reported that these were the most opportune occasions to talk about
blood awareness.

As a result, the WRAP workers supported ongoing efforts to enhance the educational
potential of the ‘sharing’ question. An immediate suggestion was the possibility of
designing a poster with some visual cues that might assist clients to think more
seriously about the ‘sharing’ question and simultaneously decrease the pressure on
workers to stimulate dialogue with clients. Clearly, there are potential benefits in
extending interactions with clients, but achieving that has constraints.

**Educator-client interactions**

It is commonly regarded in the HCV/IDU field that of all involved agencies NSPs
have the most frequent and ongoing interactions with users and, as such, the locus of
pedagogy is overwhelmingly in client interactions at the moment of equipment
provision. Over the course of the action research, research staff observed several
dynamics that affected the potential to engage in effective prevention education at
WRAP. The group exercise (described above) revealed some of the dilemmas and
problems faced by NSP workers in facilitating meaningful interaction, but there were
other elements critically affecting delivery of education to WRAP clients.

**Small talk as a catalyst**

The ability of staff to engage in ‘small talk’, particularly their ability to initiate
conversation even when so many clients want to enter and leave the NSP rapidly, was
a critical factor in extending any educational dialogue. Though this may seem self-
evident, like any organisation interested in providing effective customer service, there
is more scope for NSP workers to employ those types of strategies more likely to
enhance ongoing conversation. Those WRAP workers more adept in this respect were
able to recall something of interest about a client, even if they had only attended the
centre once or twice, and had quickly established a rapport with that client. On other
occasions, particularly with first-time clients, some WRAP workers would quickly
identify something that could ‘lighten’ the interaction, e.g. observing a client’s T-Shirt
decorated with a rock star’s motif and asking the client what they thought of the star’s
latest album.

These might seem small matters, but they are the core of educational moments and
reveal pedagogy in action. Yet, important as these pedagogic skills might be, they
rarely translate into stated duty requirements for NSP workers. The closest two of
seventeen items in WRAP’s NSP worker duty statement require staff ‘to provide a
friendly and non-judgmental environment for clients’ and ‘to provide safer injecting
technique education and needle and syringe decontamination education to clients of
the service’. These abilities are obviously similar to those required of many educators,
particularly with hard-to-reach populations. What is unique about NSP worker
abilities at a fixed site like WRAP is the consistent need to apply such techniques in
the midst of busily providing injecting equipment in a small, often crowded space. In
other words, workers deftly have to combine both the roles of salesperson and
checkout customer assistant. And, in so doing, workers need to strike a balance
between engaging the client and avoiding ‘overloading’ a reluctant client with too much intrusion.

At a regular in-service training session for new rostered staff, it was stated that ‘we only encourage people to talk about an issue if they raise it’ and ‘we want to avoid a “rescuing” mentality’. WRAP’s operational guidelines, updated in January 1998, state that ‘Clients seeking services over and above needle exchange are encouraged to make appointments with staff, however attempts will be made to respond on a needs basis. “Drop-in” style of service is not promoted.’ During the action-research observations very few of these appointments were ever sought by clients, and those that did occur usually involved WRAP staff assisting a client to obtain appropriate treatment services.

The need for educational leadership

The limits on extending interactions with clients are not only affected by the brief nature of the equipment-provision event itself, but also are subject to staffing continuity. Logically, the longer staff members work at the NSP (in terms of weekly hours and length of employment), the more intimate their knowledge of clients. However, given resource constraints, few NSPs including WRAP can afford to employ full-time workers. With the WRAP coordinator occupying the only full-time position, the three half-time NSP officers rarely have effective opportunities to share knowledge about clients and client interactions with each other or with the four rostered casual staff. A regular one-hour Friday staff meeting offered some opportunity but it could not involve all staff. Also, it was often interrupted by continuing to service the NSP and was usually preoccupied with administrative issues rarely conducive to deep reflection about client interactions and educational practice. There are clearly valid administrative needs to be met in these staff meetings. But staff meetings cannot substitute for staff reflection on educational issues.

This is not to discount the value of regularly observed informal discussions among workers, often occurring in the lull between clients attending the NSP. Nor does it overlook the vital role played by an experienced educator officially based at WRAP throughout 1998 to conduct her own action-research with Vietnamese clients and invariably becoming involved with broader issues at the centre. All WRAP workers specifically noted the inestimable value of this ‘sounding board’ provided by an experienced educator. Similarly, when available, the coordinator was also able to offer her experience for the workers to reflect on particular issues, though administrative imperatives often demanded her primary attention. This confirmed the need for a more formal experienced educator to be available as a resource, where one staff member’s principal duty would be to assist workers and clients in their educational interactions.

Identifying with clients

In conversation with research staff, all agency staff were quick to point out that to be seen as ‘peer educators’ was not as critical as being seen to be non-judgmental. All workers said in the informal, one-on-one interviews with research staff that they do not call themselves ‘peer educators’. One comment was ‘you need to still be using to really gel with users’. Some went so far as to say it was inappropriate to identify as a user for ‘I’ve yet to meet a person who says “It’s good to be a user”’. WRAP workers did feel, however, they could relate to users’ other life experiences and this was one
moment when genuine rapport was established with clients. For example, one worker said: ‘They’ll blurt out a comment about something in their life when you least expect it, and you hold on to that and remember it for next time’.

**Interactions beyond equipment provision**

Given the hectic nature of most moments of equipment provision, there are few other educational opportunities where communication with NSP clients can occur. WRAP is constrained in its focus on equipment provision. As its operational guidelines state: ‘Needle exchange is the Program’s primary focus and has priority over all other services/activities undertaken by staff’. With ever-increasing numbers of clients, it is simply not possible for NSP workers to develop any substantial educational interventions with clients. Certainly, there were several observed occasions when workers expressed frustration at not having more opportunities to conduct group sessions, away from the frantic point of provision of injecting equipment.

To this end, WRAP have designated such a role to the community development worker/education officer, but her half-time duties appear to be occupied more with attending to WRAP’s important liaison work with the broader community than in working directly with clients. It is clearly difficult for one half-time worker to be expected, for example, to ‘maximise opportunities to educate clients on safer drug use including HIV, hepatitis prevention, vein care and the impact of indiscreet drug use’ when the position description includes another thirteen specified activities and responsibilities.

With its high volume of regular clientele, WRAP, at least in principle, is ideally placed to extend client interactions beyond the moment of equipment provision. Indeed, ever since its establishment as a fixed NSP, WRAP has sought to involve clients as volunteers in the day-to-day operations of the service. We note the importance of the activities that encourage WRAP’s clients to contribute to a WRAP users’ magazine, a resource design competition, safer disposal practices, and similar initiatives. However, with so few resources available, no strategy has yet been devised to formalise the apparent eagerness of many clients to participate. WRAP is aware of the need for such a strategy, for during the action research period WRAP hosted a student on placement whose core project involved writing a plan on how WRAP might proceed to establish and maintain a volunteer base.

**Research**

Two other action research projects conducted at WRAP in the past twelve months demonstrated the rich possibilities that exist for facilitating more in-depth communication and education with local users. The Vietnamese IDU and Harm Reduction Project, co-sponsored by the Macfarlane Burnet Centre for Medical Research, was able not only to establish an informed and educated peer group of Vietnamese users, but also one that could share information and education with their peers long after the life of the project. Also, in the second half of 1998, the WRAP coordinator’s postgraduate research involved hosting four focus groups of young users discussing their using practices, followed by a survey of seventy-eight WRAP clients. As a direct result of this research, plans for a ‘Disposal Peer Education Project’ were well under way by the end of that year.
These initiatives reveal not just the capacity of research to make a difference, especially when geared to problems of practice, but also confirm the importance of the educators themselves to the task of developing better educational practice. They also suggest that a systematic incentive plan to support such initiatives might be a useful way of encouraging educators to take their ideas further and enable them to create a ‘space’ that allows new things to be trialed and, if effective, be incorporated into practice.

A.4 Other issues relevant to program delivery and design

Modes and forms of planning

Research staff observed little systematic time for forward planning by staff members with the exception of the community development worker and the coordinator, whose schedules routinely also required promoting the role of WRAP in the general community and sitting on a number of relevant committees. For all other staff, schedules were dictated by the needs of the NSP and, in this respect at least, there would appear little need for formulating detailed daily/monthly work plans. Apart from annual planning days, weekly staff meetings included some planning on behalf of the organisation. However, with the main job requirement being to service NSP clients, no individual NSP worker was obliged, for example, to formulate a plan to juggle competing priorities for education. For the organisation itself, planning did occur at Program Advisory Committee and Community Liaison Committee meetings, although reports from these meetings indicate that most of WRAP’s work is reviewed and overviewsed there rather than previewed and planned.

Feedback collection techniques

WRAP workers have two communication books available to record details on interactions with police and clients respectively. The client communications book is designed to reflect records written in the ‘comments/referrals’ section of a statistics sheet requiring more extensive documentation, but this was not in fact a regular activity. In addition, a May 1998 Planning Day had stressed the importance of staff debriefing procedures, but it appeared that this had yet to occur. In this sense, this reflects a need poorly served by a process, and as such is ripe for re-jigging through reflexive practice.

Documentation

WRAP staff are rostered to collate the monthly statistics, which provides them with some opportunity to reflect on the past month’s service delivery to clients. However, agency staff were very seldom able to document their work in any other systematic way. Apart from the communication or client contact books, the resources simply do not exist to foster the creation of better documentation practices. The net effect is that much of the good work done at WRAP is lost, unverifiable and less able to prove itself. A second consequence is that, with rapid staff turnover and a lack of adequate staffing resources, various efficiencies that come from developing better documentation, communication and fostering a corporate educational memory are foregone. The two group exercises conducted by research staff clearly revealed a rich
body of knowledge awaiting the benefits of systematic documentation and reflection. Again, severely limited resources and pressing schedules deem reflexive practice somewhat a luxury in a busy NSP such as WRAP.

**Resource utilisation**

Most WRAP staff update their IDU knowledge and information from within the confines of the office and its resources, including daily newspapers, *Good Liver* (Hepatitis C Council of Victoria) and *Connexions* (CEIDA). Otherwise, staff utilise a directory that includes a full list of NSPs and HCV-trained GPs. All staff talk of the importance of acknowledging ‘What I don’t know’ and then referring later to more experienced educators and/or other resources. In terms of the actual production of educational resources, WRAP workers organised a design competition in the first half of 1998 called ‘Clean Fit, Clean Hit, Clean Up!’ which resulted in an entire wall of the centre being dedicated to safe disposal education. Images of public disposal bins were placed on a wall map of the Footscray area with the bin sites clearly indicated. Small, laminated flip cards with relevant information in English and Vietnamese were produced during 1997-98 and have proved to be a popular resource. WRAP is also in the process of updating and translating a pamphlet on Normison, an increasingly popular drug of choice for Vietnamese users.
B. The ‘SCIVAA’ Program

The Sunshine Coast Intravenous AIDS Association (SCIVAA) joined the action-research component later than the other two agencies after another user group had to withdraw. We are grateful to SCIVAA for joining the project and for participating with such goodwill. However, as a consequence of the late start, it should be noted that the period of time research staff had to work with SCIVAA was limited.

B.1 Description of the SCIVAA Program

Philosophy and aims

SCIVAA is a non-profit, community-based organisation providing information, education and project development in the prevention of HIV/AIDS and hepatitis C among people injecting drugs. SCIVAA seeks to provide services based on the framework and strategies of ‘harm reduction’. SCIVAA aims to encourage BBV prevention and facilitate community participation and ownership of peer education and projects on the Sunshine Coast of Southeast Queensland. It is a membership-based organisation that encourages people who use drugs illicitly to become members and have a say in the organisation. SCIVAA also aims to provide open access with an operational structure that offers non-judgmental support in relation to lifestyle issues and referral and advocacy to people who inject drugs, their peers and families.

Role and function

SCIVAA offers drug education, advocacy, referral, and needle and syringe provision services which operate from the premises between the hours of 9:00am to 5:00pm, Monday to Friday. SCIVAA also provides occasional home delivery of needles and syringes upon request where possible. SCIVAA’s offices are based in Maroochydore and the organisation has a mandate to provide services to the entire Sunshine Coast region from Redcliffe, an outer northern suburb of Brisbane, to Gympie, 200 km north, and Kingaroy, 150 km west.

Governance

The operation of SCIVAA is overseen by a community-based Management Committee consisting of interested members of the Sunshine Coast community and is open to people who use drugs and their friends. SCIVAA tries to get active users involved in the Management Committee but they often have difficulties getting people to turn up. Most, but not all, people on the Management Committee are ex-users. The Management Committee includes a President, Vice President, Secretary, Treasurer and four ordinary members. The Management Committee is re-elected each year at the Annual General Meeting of the organisation. The SCIVAA coordinator attends Management Committee meetings ex officio. Generally, a ‘majority rules’ decision-making process exists. When agreement cannot be reached, an independent mediator or outside person on staff selection panels ensures an impartial, independent position or
decision is reached. The funding body (Queensland Health) is present at an Annual General Meeting and are consulted if there is a particular problem. At the moment there is no induction/training process for new Management Committee members but they are eager to address this problem.

**Staffing**

SCIVAA has five part-time staff: a coordinator (30 hrs p.w.); a Queensland Needle Availability and Supply Program (QNASP) worker (30 hrs p.w.); an IDU education worker (25 hrs p.w.); a hepatitis C education worker (20 hrs p.w.); and an administration worker (15 hrs p.w.).

**B.2 Institutional issues**

**Human resources**

SCIVAA has had a high turnover of staff over the last eighteen months—not uncommon in the community HCV/IDU sector. At the time of the action research, the coordinator had been in this position for twelve months. Every other staff member had been at SCIVAA for less than six months (e.g. the QNASP worker had been employed for four weeks, the IDU education worker had been there for four months, and the administration worker for three months). In addition, there were two new hepatitis C educators in succession in the time research staff were there. One week into the action-research, the newly appointed hepatitis C educator resigned and another worker had to be found to fill the position. This meant that the action research had already been going for two weeks before the new worker started. This second hepatitis C educator was still getting used to the job when the action research finished.

SCIVAA originally applied for a thirty hours per week hepatitis C educator but received funding for only twenty hours per week. The hepatitis C educator position does not have any project, administration or management funding. SCIVAA staff regard it as unrealistic to expect this part-time position to meet the needs of all the HCV-positive users and provide all the HCV prevention education for the entire Sunshine Coast region.

The coordinator’s position is not funded full time, so she is limited in providing program coordination to four days a week. During this time she also takes responsibility for all the agency networking, media and profile building, and negotiating with State and Local Governments. This is undoubtedly more than one part-time worker can manage.

Moreover, in the last two years the number of client contacts and the amount of NSP equipment provided by SCIVAA has increased by 200%. The QNASP position is only funded for 30 hours per week, covering four days per week. The coordinator believes that SCIVAA needs to open one night a week as well, but without volunteers it cannot even keep the NSP open the required five days per week.
Volunteers staff the NSP three days per week but many tell of problems with stigmatisation. As one Management Committee member reported: ‘They get marginalised by their peers for volunteering at a user organisation’. The only volunteers who stay are those who have a deep personal commitment to the issues, often ex-users. But relying on voluntary assistance, no matter how committed and useful, is not the answer.

SCIVAA is still funded on the basis of levels of service provided two years previously. SCIVAA is now surpassing its annual targets for needle distribution each quarter with no additional funding. This issue of adequate baseline staffing resources is crucial to HCV/IDU prevention education and suggests that a benchmarking assessment, similar to that being undertaken in 1999 in gay men’s HIV/AIDS education in Australia, is warranted in this sector.

Staff development

SCIVAA is only funded to the level of $400 per year for staff training and they receive no funding to provide external supervision for staff support. As a consequence, there is very little or sometimes no training available for workers. SCIVAA is, therefore, very dependent upon the skills new workers already have. Trained staff are scarce and sometimes SCIVAA has to employ people with skill deficits and then find resources to provide skills development opportunities for the new worker. When some training does occur, the high staff turnover means that departing workers take away the skills they have developed at SCIVAA. The Management Committee is attempting to address the issue of skills drain due to high staff turnover through staff skills development and policy development.

It should be pointed out that this is not a problem unique to SCIVAA. Irrespective of any individual organisation’s strengths and weaknesses, the problems of high staff turnover, skills depletion, training needs and inadequate resources were reported consistently across the sector.

Environments

SCIVAA’s environment lends itself to clients’ browsing for information before entering the premises without feeling pressured by workers watching or standing near them. There is an information stand in the front of the building at the top of the stairs containing pamphlets and written materials on BBV, STI transmission, living with HCV and HIV, drug use issues, welfare referrals, etc.

In the NSP room itself there is a white board and a series of pamphlet and booklet shelves. The white board is filled with educational messages on issues that receive frequent mention by clients of the NSP at any given time. These can range from hepatitis C and HIV prevention, safer drug use and harm reduction information specific to other issues experienced by their clients. Clients can see these messages and browse for information while the QNASP worker makes up their equipment request.
External relations

There are also external relations that impact upon SCIVAA’s ability to carry out services, including the provision of HCV prevention education. SCIVAA sees itself as situated in a particularly conservative community and political environment. This has had an impact on SCIVAA’s capacity to raise its profile or expand its services. The SCIVAA coordinator attends a number of interagency meetings in the region, but she noted that SCIVAA often had to fight to get onto committees: ‘SCIVAA is often marginalised by other services in the Sunshine Coast area. We are left out of things all the time’. Indigenous Australians rarely come to SCIVAA, even though it is estimated that about 5,000 indigenous people live on the Sunshine Coast. The presence at times of local police and the fear of harassment could explain the reluctance of indigenous people and others who inject drugs to make use of SCIVAA’s services. As one staff member reported: ‘Word gets around quickly if they [the police] have been hanging around SCIVAA’.

B.3 Action research project

Methods used

As stated earlier, the starting date for this agency in the action research was delayed and this resulted in research staff being able to spend only four weeks at the site. Research staff did carry out one-to-one semi-structured interviews and informal discussions with both successive hepatitis C educators, the IDU education worker, the coordinator, some volunteers and one Management Committee member.

Research staff used ‘critical incidents’ story-telling techniques with the IDU education worker (hereafter, the agency educator) to assist her to recount significant situations that arose during the provision of education and reflect on these to identify pedagogical techniques. Research staff also reviewed written materials from workshops carried out by the agency educator including workshop development, agendas, evaluation and feedback forms in order to uncover other possible aspects of pedagogy.

Education in practice—the ‘Grid Exercise’

Research staff carried out reflexive practice exercises, including the ‘Grid Exercise’, in workshop sessions with agency staff. These involved brainstorming ways of learning, identifying where education occurs in relation to their work, and reflecting on the value and efficiency of these activities. Table 14 summarises the exercise.
### Table 15: SCIVAA ‘Grid Exercise’

<table>
<thead>
<tr>
<th>Individual/informal</th>
<th>Individual/formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussions with general community members</td>
<td>Initiating an exchange of info. from client to worker while doing equipment provision</td>
</tr>
<tr>
<td>Discussions with peers</td>
<td>Sessions with past workers</td>
</tr>
<tr>
<td>Talking to clients when they have ‘tea’ at SCIVAA</td>
<td>Formal handover from previous to new worker</td>
</tr>
<tr>
<td>Driving alone</td>
<td>Formal external supervision: self initiated</td>
</tr>
<tr>
<td>Lying in bed at end of day</td>
<td>Peer with some ‘professional’ background, more skills/experience in managerial skills</td>
</tr>
<tr>
<td>Discussions with partner at home and on computer</td>
<td>Making up packs for clients and talking to them while doing this</td>
</tr>
<tr>
<td>Computer at home when ideas come up form</td>
<td>Assessment/referral of clients in crisis</td>
</tr>
<tr>
<td>One-to-one discussions with work colleagues</td>
<td>Re-typing SCIVAA policy and procedures manual</td>
</tr>
<tr>
<td>Running into clients, being approached on the street</td>
<td>Answering the phone, i.e. clients’ requests</td>
</tr>
<tr>
<td>Reading brochures, old <em>Fitting News</em>, other journals</td>
<td>Knowledge gained through running external training</td>
</tr>
<tr>
<td>Discussions with other workers from community sector</td>
<td>Reading HCV ‘train the trainer’ manual</td>
</tr>
<tr>
<td>Informal education</td>
<td>Reading CEIDA training manuals</td>
</tr>
<tr>
<td>Seek and give new info. (over phone) to other community workers</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Collective/informal</th>
<th>Collective/formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conversations with past workers</td>
<td>Qld BBV prevention planning day at (Qld Health)</td>
</tr>
<tr>
<td>Group discussions among staff</td>
<td>Group sessions with past workers</td>
</tr>
<tr>
<td>Discussions with peers</td>
<td>Staff meetings (every two weeks)</td>
</tr>
<tr>
<td>Discussions with other community members</td>
<td>Half yearly planning day (outside of SCIVAA)</td>
</tr>
<tr>
<td>Conversations with friends and partners in the car</td>
<td>Facilitating volunteer training</td>
</tr>
<tr>
<td>Individual guidance from coordinator -task oriented</td>
<td>Facilitating and conducting QNASP authorisation training</td>
</tr>
<tr>
<td>Informal orientation</td>
<td>QADREC training calendar in Bris. (when they can attend)</td>
</tr>
<tr>
<td></td>
<td>Organising running of schoolies week events</td>
</tr>
<tr>
<td></td>
<td>Outside training</td>
</tr>
<tr>
<td></td>
<td>SHHAAG interagency education working group (all SHHAAG educators/workers)</td>
</tr>
<tr>
<td></td>
<td>Networking interagency meetings</td>
</tr>
<tr>
<td></td>
<td>Team building at staff meeting</td>
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<tr>
<td></td>
<td>fortnightly/weekly</td>
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</tbody>
</table>
Identifying these activities is important, for it forms a substantial list of reflective techniques, offering a ‘menu’ to SCIVAA to utilise more readily within the organisation to improve the quality of its service delivery and education. A second result of this process was the nomination of some strategies to implement changes that might assist the organisation—another example of reflexive practice in action. These strategies were:

- blocking off formal times at work to keep updated with reading materials;
- develop twelve-month work plan, out of this pull together three monthly and fortnightly activity lists;
- formalise and integrate worker handover into orientation package;
- develop orientation, induction pack for new staff;
- formalise discussions with general community members;
- ongoing and consistent coordinator/worker supervision (schedule time slots);
- develop potential list of free external supervisors;
- write-up information policy and procedures manual and set time of one hour per month in work time to attend external compulsory supervision;
- formalise an agenda item for every second staff meeting for individual and collective staff-training needs;
- seek alternative forms of funding for staff training.

Interaction with clients

The main type of client interactions that occurs at SCIVAA is the provision of injecting equipment. Education is provided when opportunities arise to engage with the client during the provision. To this end, a volunteer has tried to get the service re-orientated to become more of a drop-in centre. A few users did drop in for a while, but then the police started ‘hanging around’ and the local users lost trust and confidence in SCIVAA. Gradually, this confidence is being re-built.

When someone wants injecting equipment, they have that purpose as their main reason for coming to SCIVAA. The educators often have a different agenda in mind, beyond equipment provision. As one volunteer remarked, ‘Often when clients come into the [NSP], the workers are focused on trying to get info out of the client about what is going on rather than the worker trying to give education to the client’. Perhaps the NSP’s biggest educational obstacle is the fact that clients have to climb two flights of stairs and then walk through the main socialising area in SCIVAA to a small, poorly lit room to receive equipment.

The QNASP worker employed a deliberate strategy of not having injecting equipment packs already made up in the NSP room, in order to increase opportunities for education to occur. This allowed the QNASP worker to engage the client in conversation while making up the client's equipment pack. He would question the clients carefully about the kind of injection equipment they were using and provide some HCV prevention and harm-reduction information relevant to the drugs the clients were using and the way they were using them. In so doing, the QNASP worker also had the opportunity to hear about current trends in drug-taking and risk behaviour and could encourage clients to disseminate educational information among their peers, many of
whom may not attend the NSP. It was a clever educational manoeuvre on the QNASP worker’s part.

Educational skills and style

Research staff asked the agency educator ‘What makes a good educator?’ and received the following list of characteristics:

• either good information or access to good information;
• respect for target groups;
• good manner and way of relating (appropriate to target group);
• being aware of target groups’ needs and issues;
• being open to the needs that are presented;
• being perceptive.

Another SCIVAA educator added the following to the list:

• sense of humour counterbalanced with seriousness;
• being articulate and speaking clearly;
• good preparation and presentation;
• stimulating visuals and using more visuals;
• showing by examples (by modelling or by using case studies);
• good subject knowledge and confidence in it;
• good timing;
• researching groups being educated and knowing who your audience is;
• training and skills development, putting it together;
• training in adult education, teaching, learning and theory (‘It is really crucial. You need to have a basis, a foundation to draw from.’);
• skills, practice, intuition;
• a reading group;
• evaluation.

In terms of pedagogical techniques, the agency educator constantly spoke of the importance of humour. ‘People respond better if you can have a joke with it, not at the expense of it. Humour facilitates the educational side of it. Humour affects your concentration span and makes it more interesting’. Aside from this, she was acutely aware that ‘information provision is not always education’. What was more difficult to ascertain was how that insight was able to make its way into SCIVAA’s educational curriculum and its program planning.

Training

The agency educator provides in-house training to staff of the organisation, using didactic input in the main, along with some group work, interactive discussion and reflection. The agency educator was also obliged to undertake educational programs for other service providers. These covered a range of topics from alcohol and other drug issues to BBV prevention, dealing with specific drugs, drug pharmacology, and hepatitis C drugs to personal issues such as having Christmas with families. These workshops were also open to users and members of the general community.
Identification with clients

There is no discrimination against users applying for jobs at SCIVAA and there is a clear policy in relation to drug use in the workplace. That non-discriminatory approach sits somewhat uneasily with a more dominant ex-user culture, which can often take the shape of the notion ‘We did it [got off drugs] one way; therefore, why can’t you “get clean” that way!’ This tension between users and ex-users is only one of many this study noted in the key stakeholder interviews. There is not always tension between the groups, but the issue of current and previous using is likely to present the field of HCV education with frequent difficulties not just in prevention education but also in health education for people with HCV. There is some sector-wide conflict resolution work to be done here by peak agencies to ensure that this potentially divisive tension is resolved as best it can be in the near future.

B.4 Other issues affecting program delivery and development

Modes and forms of planning

SCIVAA holds one major organisational planning session per year. From this planning session each staff member is asked to develop a three-month work plan which is reviewed and re-prioritised each quarter. In turn, from this quarterly plan each staff member develops a fortnightly activity list. Some planning also occurs at staff meetings, held at least fortnightly, and to a lesser extent at monthly Management Committee meetings.

Planning for education and training is less formally organised. The agency educator is attempting to formalise this somewhat by including a regular agenda item on staff training needs at every second staff meeting. The aim is to consult with other staff on input as to their training needs and information gaps and how they would like them to be addressed.

Several SCIVAA staff participated in a hepatitis C and drug users planning day organised by Queensland Health. This was initiated because of a lack of services for HCV positive users on a state-wide level, particularly in regional areas. The planning day brought together representatives from the Queensland user groups and other community sector agencies to address gaps in services in large provincial towns like Cairns and Rockhampton. Most participants favoured funding activity at the local level rather than a centrally funded coordination of HCV prevention activities for users across Queensland. This is yet another recognition by educators of the importance of understanding the local nature of user networks and of the specific character of using ‘scenes’ as localised phenomena requiring local interventions.
Feedback collection techniques

SCIVAA educators use a number of standard evaluation techniques to gather information about the quality and acceptability of their educational interventions, including participant feedback forms, monitoring of injecting equipment return rates, analysis of the evaluation forms, and verbal feedback.

However, these evaluation techniques, no matter how useful on the surface, have yet to be inserted into a subsequent reflexive practice process. This is not easy to do under the current pressures described above in this report, but it does point to the tendency in the sector to undertake evaluation because it is required and because it is seen as useful—to whom?—but which lacks an implementation phase that makes effective use of what evaluation findings might offer.

Documentation

The agency educator documents the development, delivery and evaluation of all in- and out-of-house training sessions, including the volunteer training, police training, health care worker and staff training sessions provided. These are documented largely to provide a guide to future workshop development, for accountability, and to assess the effectiveness of training through the analysis of participant-feedback forms. Other information is collected from the QNASP worker to provide statistics on the number and type of injecting equipment being provided, to whom it is provided, and whether clients required further referrals. Telephone inquiries are noted to provide statistics on the number and type of information requests met within specified periods of time. These are all standard accountability techniques and they take time. They are yet to be utilised in a systematic reflexive practice process, where they might add to other more important techniques of monitoring the effectiveness of educational activity.

Resources

Like most of the small user groups, SCIVAA has great difficulty in obtaining adequate resources. SCIVAA does not have sufficient funds to produce its own print resources or educational campaigns, and instead relies on QuIVAA and other user groups producing print materials. The agency educator is also unable to employ peer educators from within networks of people who use drugs on the Sunshine Coast due to lack of resources. Therefore, the agency educator uses mainly face-to-face, verbal interactions and didactic techniques to provide education to service providers. The same kind of written materials are provided to clients upon request.

SCIVAA produces a newsletter, *Fitting News*, once a quarter and much of the education and engagement with the target audience is conducted through this newsletter. The newsletter often contains information on HCV and HIV transmission prevention, drug use issues, legal issues, health promotion, service provider and referral information, and information about SCIVAA’s activities and services. The agency educator is attempting to encourage users to
their own stories to the newsletter, but at present the majority of content is developed by the staff of the service. The IDU educator uses a series of reproduced pamphlets and handouts on drug use issues, alcohol and other drugs training, attitudes and values, and a small amount of BBV prevention written material. She also relies heavily on the CEIDA drug education series of training session handouts and NUAA resources to develop her workshop.

In terms of specific hepatitis C resources, the hepatitis C educator used various special topic pamphlets including ‘HCV Contacts’, ‘Women and HCV’, the Hepatitis C Council of Queensland pamphlet series ‘Hep C: what you need to know’, and the ‘Hep C Review’ from the NSW Hepatitis C Council. For service provider training, she used specific training resources such as the ‘Hep C Manual: Train the Trainer’ (WA Hepatitis C Council, 1997), the ‘Hep C Introductory Training for GPs and Hep C Workers’ (Hepatitis C Council of Queensland, 1998) and a number of standard videos on hepatitis C. The previous hepatitis C worker used mainly medical material on HCV infection such as ‘Viral Testing in Hepatitis C Therapy’, the Royal Australian College of GP’s ‘National Hepatitis C Education Program for General Practitioners National Management Guide’ and the Hepatitis C Council of Queensland’s ‘Hep C News’ which mainly covers treatment and care issues.
C. The TRIBES Project—‘The Game’

C.1 Description of ‘The Game’

Philosophy and aim

‘The Game’ is a project funded through the TRIBES program, which is administered by NUAA and funded by New South Wales Health. The TRIBES program provides grants to specific groups (subcultures or ‘tribes’) for short-term, one-off educational projects that aim to reduce the potential harms associated with injecting drug use, particularly the transmission of HCV or HIV.

In the context of this program, a ‘tribe’ is defined as a group of people who share a subculture and identify and relate to each other because they have a number of things in common such as: a particular style of language (e.g. slang expressions); a common set of behavioural patterns; similar recreational activities; a shared taste in music; similar drug or drugs of choice; or living in a similar geographical area.

Project role and function

There are three main components of the project:

1. The delivery of skills development workshops by the project worker with ‘tribe’ members to assist them in carrying out the project, in particular in peer education workshops and meeting procedures. Communication, assertiveness and modelling appropriate behaviour were also important components of this skills development process.

2. The development, delivery and evaluation of a series of health education workshops conducted by the young ‘tribe’ members and targeting other young people who were at risk of acquiring or transmitting BBVs and STIs. These workshops covered topics such as drugs and alcohol, general health, sex work, and homelessness.

3. The development, focus testing and evaluation of a print resource using the medium of a board game that focuses on young people, BBV and sexual health promotion.

Management

The auspicing body for ‘The Game’ project is Foley House, a community-based, short-to-medium term, crisis accommodation service that operates with a harm reduction philosophy. Foley House targets homeless people who inject drugs and who may engage in work in the sex industry. The project is overseen by a Steering Committee comprising several ‘tribe’ members, the project worker, a representative from the auspicing body and the NUAA TRIBES manager.

Staffing
The project employs one primary worker who was initially recruited from the Foley House staff. She is now employed by another community-based organisation but continues to work on the project. Four young people who inject drugs make up the core group of ‘tribe’ members working on the project. They are employed as peer educators and one of their tasks have been to develop two health education workshops each and deliver these to other young people. The young people are also paid for the contributions they have made to the design, development, focus testing and redrafting of ‘The Game’ resource. Over the duration of the project up to fifteen young people from Foley House have been significantly involved in ‘The Game’.

C.2 ‘The Game’ resource

‘The Game’ is played by spinning a wheel, then counting and moving the relevant number of squares. The player lands on a coloured square and each colour relates to a type of question. Questions come in a range of forms (e.g. celebrity heads—guessing game—and general theme questions relating to safe sex, safer injection, drug-related harm reduction, and BBV prevention), as do the forms of required responses (e.g. drawing, demonstrations or situation role plays). Each correct answer gets a set number of points. Some questions have an answer written on the back; others rely upon group discussion facilitated by the youth worker or young people/peer educators who are overseeing the playing of ‘The Game’.

‘The Game’ provides a means of reinforcement of health promotion strategies, which the players get to practise. It works on the rationale that people are more likely to take in information during a state of high arousal. Consequently, young people are able to play ‘The Game’ when they are intoxicated, maximising the window of opportunity for education in often very hectic lifestyles. This resource also works on the principle ‘people who can’t own their past can’t look forward’. ‘The Game’ assists people coming to terms with their past by identifying the learning that has occurred in their lives. Survival skills are validated and players are encouraged to take stock of their own knowledge in a very immediate way. ‘The Game’ is promoted as being suitable for use by any group who has a health focus including correctional services, rehabilitation centres or health services that work with marginalised young people.

C.3 Institutional issues

Relationship with the funding body

In the most recent funding round NUAA staff took on a co-management role to assist the TRIBES manager to oversee all fourteen individual TRIBES projects. Due to unforeseen circumstances, ‘The Game’ ‘tribe’ did not get the usual induction session from the TRIBES manager and other NUAA staff. They also did not get a copy of The TRIBES Handbook, which outlines roles and responsibilities, expectations, processes of communication and consultation. As a result, ‘The Game’ ‘tribe’ did not have a clear understanding of the level of support and resourcing available to them. Both the project worker and the ‘tribe’ members/peer educators said that this had an impact on their ability to carry out the work effectively. For example, during the focus-testing component of the project the ‘tribe’ members and the project worker decided that a
support video would be needed to explain and model the process of playing ‘The Game’. The budget did not allow for this and the ‘tribe’ were not aware that they could apply for enhancement funding in the next TRIBES funding round.

The project worker was also unaware that the TRIBES manager and other NUAA staff were available to assist with the provision of information and skills during the course of the project. Research staff raised these issues with the TRIBES program and NUAA. This resulted in a review of communication between the TRIBES manager and NUAA staff co-managing TRIBES projects. A plan has now been established that includes regular feedback, support and reporting of all meetings between NUAA staff co-managing TRIBES projects and the ‘The Game’ project manager.

As a result of these difficulties the timeline for the ‘The Game’ project needed extending. This required a high level of flexibility and understanding from the auspicing body, who fortunately responded well. Payment schedules were regularly changed to fit in with the availability of the ‘tribe’ members/peer educators, and compromises were made in relation to how long and how often the ‘tribe’ members/peer educators worked on the project. As a result of this flexible approach, the project actually continued (within budget) long after the original timeline had expired.

Environments

The utilisation of physical space was not a particularly relevant issue for ‘The Game’. There were some difficulties in securing meeting spaces, but this was resolved with the support of the auspicing body who made meeting space available for the ‘tribe’. Space availability was a factor in choosing where to conduct the peer-focused health education workshops. It was decided that the most appropriate places to do this were at services that the target group regularly use such as youth services and crisis accommodation centres. The project experienced some difficulties in securing these sites because many of these youth services were reluctant to accommodate workshops targeting young people in relation to sex and drug use issues, particularly when the people providing the education were young people who inject drugs themselves.

External relations

The project worker expressed frustration at feeling isolated, especially because she believed she was the only person doing this kind of peer education work. She spoke of a lack of support from some co-workers who seemed cynical about the possibility of educating these young people and the potential benefits it may bring. More practically, a high degree of scepticism existed about the ability of these young people to carry out the project or to be able to provide any meaningful education to their peers.

C.4 Action research project

Methods used

Research staff used the following methods during the ten-week observation of ‘The Game’ project:
attended weekly workshops with the project worker/educator and the ‘tribe’ members to observe and participate in the development of playing ‘The Game’, including rules, instructions and point scoring;

- carried out face-to-face interviews and informal discussions with the project worker, ‘tribe’ members, and management of Foley House;

- conducted semi-structured interviews and consultations with the NUAA/TRIBES manager and the NUAA coordinator;

- used ‘critical incidents’ story-telling techniques with the ‘tribe’ members/peer educators to assist them to recount significant situations where they provided education to their peers;

- reviewed written materials from workshops carried out by the ‘tribe’ members/peer educators with other young people including workshop development, agendas, evaluation and feedback forms;

- conducted reflexive practice exercises in group workshop sessions with ‘tribe’ members/peer educators and the project worker that involved brainstorming ways of learning and identifying where education occurs in this project.

**Education in practice—the ‘Grid Exercise’**

Research staff conducted reflexive practice exercises with the ‘tribe’ members/peer educators and the project worker. The purpose of the ‘Grid Exercise’ in this case was to assist educators to identify the contexts and structure of educational experiences in relation to their work. The information generated in the ‘Grid Exercise’ by ‘The Game’ ‘tribe’ members differs from that collected in the other action-research projects. In this case, the young people participating in ‘The Game’ were not only participants in an educational activity, they were educators as well, taking ideas and information to various workshops for other young people. So they approached the ‘Grid Exercise’ as both educators and clients of an educator. This meant that when the ‘tribe’ members/peer educators reflected on their significant learning experiences, their ideas were often tied up with what they learned and the circumstances in which that learning occurred, as well as the educating they did and their reflections on that experience. It is not unusual for educators to report learning from their clients. In ‘The Game’, the ‘tribe’ members learned as both peer educators and clients at the same time.

**Table 16: TRIBES ‘The Game’—‘Grid Exercise’**

<table>
<thead>
<tr>
<th>Formal/individual</th>
<th>Formal/collective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Made spinner for game, TV, relaxation, wheel of fortune</td>
<td>Structured board game</td>
</tr>
<tr>
<td>Intoxication management</td>
<td>Weeding out ‘tribe’ members which developed skills around anger management, communication, assertiveness, negotiations from project work</td>
</tr>
<tr>
<td>Setting boundaries</td>
<td>This assisted the project but also allowed ‘tribe’ members to improve quality of life through applying skills developed here</td>
</tr>
<tr>
<td>How to ask for help</td>
<td>Intoxication management rules, skills development and policed by group, initially inappropriately then developed own skills</td>
</tr>
<tr>
<td>How to ‘cover your arse’</td>
<td>Trained as peer educators in role plays</td>
</tr>
<tr>
<td><strong>Informal/individual</strong></td>
<td><strong>Informal/collective</strong></td>
</tr>
<tr>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Made spinner for game in own time at home. Got idea from personal experience</td>
<td>Made board of game at home. Refined it developed prototype at home with another group member</td>
</tr>
<tr>
<td>Developed skills for financial management skills learnt through personal experience</td>
<td>Weeding out ‘tribe’ members, appropriateness of being in the group through lots of informal one-to-one discussions between ‘tribe’ members</td>
</tr>
<tr>
<td>Intoxication management direct education from peers to other participants who were acting inappropriately</td>
<td>Night out</td>
</tr>
<tr>
<td>Developed skills to mediate and work system</td>
<td>Learning to have fun in a healthy way</td>
</tr>
<tr>
<td>Setting boundaries to look after self</td>
<td>Getting to know each other</td>
</tr>
<tr>
<td>Learning your rights from other ‘tribe’ members outside the group in informal settings</td>
<td>Learning how to be in an uncomfortable position—how to adapt</td>
</tr>
</tbody>
</table>
Informal/individual | Informal/collective
--- | ---
Did the artwork at home | Learning and practising social skills (newly developed) in a supportive environment
Lots of street talk with peers to advertise project, recruit members and identify issues | Peer support and education on appropriate behaviours to get the job done
Use of observation skills learnt from life skills/experiences to identify appropriate ‘tribe’ members using street smarts | Spoke openly and answered any questions asked. Educated group on these issues
Peer support and education on appropriate behaviours to get the job done | Peer talk among ourselves about issues and choices about reacting
Learned to see things from a female perspective and to respect their opinions | |
Drawing on life experiences to train peers in safe drug use | |
Learned that I do have a choice. I can choose to act on my own rather than react to someone else | |

### Interaction with clients

In recounting significant issues in relation to the development and delivery of the health education workshops, the ‘tribe’ members/peer educators talked a lot about initial difficulties in recruiting other members to the project. In particular, they referred to the difficulties that occurred when some of the ‘tribe’ members became disruptive, abusive, or started to ‘slack off’ or failed to turn up to meetings. They talked about the importance of needing a clear and concise process for ‘weeding-out’ young people who were not seen as making a positive contribution or who were seen to be hampering the efforts of the project. The development and delivery of these health education workshops occurred prior to the action research, so this was not observed. However, research staff reviewed documents on the development, delivery and evaluation of these workshops.

### Educational skills and style

The project worker spent a great deal of time in the initial stages of the project providing education on basic life skills, in particular communication, assertiveness, anger management and intoxication management. Both the project worker and ‘tribe’ members/peer educators stressed the importance of this skills development as being essential to the effective running of the project. The ‘tribe’ members/peer educators claimed that they would not have been in a position to do any meaningful work on the project and, in particular, the health education workshops, if they had not had an opportunity to develop these skills. The project worker also used behaviour-modelling techniques and practice-based role plays to assist the ‘tribe’ members/peer educators to develop and practise these life skills in a supportive environment before they began to test their skills among each other and in day-to-day life.

According to the project worker, the most important outcome of the project has been the development of life and coping skills by the ‘tribe’ members/peer educators. She noted a marked improvement in each ‘tribe’ member/peer educator’s ‘quality of life’.
Even if a final resource (the game itself) is not ever eventually finished, she thought the project will have been a success because of the increased ability of ‘tribe’ members to deal with daily life and the consequences this has in terms of their ability to implement and promote safer behaviours among their peers, in relation to BBV and STI transmission.

The project worker offered the following insights into the abilities, qualities and skills that make a good educator:

- Being open to all ideas, your own or others.
- Learning that nothing is set in stone—have a course outline, but if something changes don’t be scared to go with it, use whatever comes up.
- Education is different from ‘teaching’—it isn’t talking at or to someone but with them.
- Being aware of and learning when the window of opportunities for education (pedagogical moments) are open and taking advantage of that.
- Understand the people you are dealing with. Being open to the possibility of recognising both verbal and non-verbal cues that indicate an opportunity for dialogue or education.
- Welfare workers and educators are born. If you’re not born a good educator then you will never be one. There are some skills you just can’t learn from formal training, i.e. qualities, personality, idiosyncrasies, inquisitive nature. Also a need to share knowledge, skills, emotions and experience. Someone who is willing to give it all up for someone else, with no fuss.
- Not tolerating injustice—by educating people you give them the skills and knowledge to exercise their rights and eliminate the injustices.
- Welfare work has very defined boundaries—when you leave work you don’t take it home. With education it’s more about sharing everything—you have to be available emotionally for people.
- Being able to put community views aside, e.g. ‘The old teacher’s adage that you can’t educate someone who’s out of it is rubbish’.
- Willing to jump in without stuffing it up.
- Prepared to make a huge investment in time. You have to have heaps of patience and a high stress threshold as you’re constantly bashing your head against a brick wall, both physically and emotionally. It’s imperative to be aware of what you as an educator are feeling and experiencing to prevent yourself from burning out.
- Be self-aware, e.g. ‘I’m scared of the boys doing their focus-testing workshop as they may think it’s shit. I have been putting the focus testing off subconsciously because of this. When you become aware of this you can develop strategies to deal with it. If you’re not aware, it could go on for ever and ‘The Game’ would never be focus-tested. I would be continuously coming up with excuses why!’
- Turning every negative into a positive, e.g. ‘If you don’t want to do it, then that’s when you should be doing it.’
- Awareness of personal traits, e.g. ‘I can be dictator. I like to be the centre of attention. I have to make a conscious effort to sit back and let the boys come up with their own answers and conclusions. This requires intense levels of self-honesty and self-examination, skills that do have to be learnt.’
- Not to be judgmental, to be aware of and actively challenge your own judgements.
C.5  Personal disclosure

The issue of how much personal disclosure by the project worker is useful for establishing credibility with the target group was raised. She thought that educators had to negotiate a fine line between disclosure as a means to establishing rapport and too much disclosure leading to burnout. She also stressed the importance of communicating with the aim of providing education. This means talking with people not at them. It is important that educators engage participants in a dialogue that has identifiable positive outcomes for the participants as well as an educational agenda.

The importance of language

The manager of Foley House believed that it was important to recruit a project worker who would be acceptable to the ‘tribe’ being targeted by the project. A large part of this was the ability of the project worker to use language that was acceptable to the ‘tribe’. This was a significant motivating factor in the employment of the project worker for the ‘The Game’.

Research staff talked with the ‘tribe’ members/peer educators about their perceptions of the project worker. They nominated her use of language similar to theirs (i.e. street-based, drug-using slang) as being an important factor in their acceptance of her and the education she provided. As they could relate to the way she communicated with them, she was able to be more of a role model to them. Similarly, the project worker thought that her life story, including her experience with drug use issues, significantly affected her use of language and, therefore, her acceptability to the ‘tribe’. She also talked about the importance of providing opportunities to widen the vocabulary of the ‘tribe’ members/peer educators to enable them to negotiate the health system and carry out tasks associated with the project such as consultations with health service providers.

C.6  Practical issues relevant to program delivery and development

Feedback collection techniques

The ‘tribe’ members/peer educators developed unique feedback collection/focus testing evaluation forms for participants in the workshops with literacy difficulties. Images rather than words were used by the ‘tribe’ members/peer educators as a way to elicit a response from those who could not read questions about their experience of the health education workshop in which they had just participated. The evaluation forms showed visual representation of questions such as:

Q. How much have you learnt?
Heaps/a fair bit/a little bit/fuck all!

Q. What presentation do you like?
Talking/writing on board/pamphlets/demonstrations/discussions/other.

Q. How are you feeling?
Happy/sad/angry/unknown.

Q. Time, is it long enough, or do you want it?
Shorter/same/longer.

Q. How involved do you feel?
Heaps/a fair bit/a little bit/fuck all.

Q. Your say?

..............................................................

The ‘tribe’ members/peer educators also used a similar evaluation form with images to focus test the playing of ‘The Game’ with groups of young people at risk. The ‘tribe’ members/peer educators used evaluation forms to feed back their thoughts on the project worker's performance in the skills development workshops and also evaluated each other’s performance. The project worker herself used brainstorming techniques in group discussion to elicit feedback on her own, and the project’s performance.

**Modes and forms of planning**

‘The Game’ project has a formal Steering Committee which meets quarterly to assist with the ongoing planning of the project. ‘The Game’ project worker carried out skills development workshops with ‘The Game’ ‘tribe’ members/peer educators in basic project planning, agenda setting, and project plan review and prioritisation processes, enabling ‘tribe’ members regularly to review work plans and re-prioritise on the basis of these. The project worker had regular supervision sessions with the Foley House Manager to assist with the planning and review of plans for the project.

**Documentation**

The project worker took and kept notes from each of the production workshops including agendas, discussion, and any outcomes or actions arising from the meetings. Documentation of the process of developing the health education workshops, self-evaluation, peer-evaluation and participant-evaluation forms were also collected during the course of the project. The process of developing ‘The Game’ resource was documented throughout the project, mainly in the form of meeting agendas, minutes, actions, or tasks and outcomes.

The project worker and ‘tribe’ members/peer educators used standard block reporting pro formas to report on the progress of the project to the TRIBES manager. The project worker was also responsible for keeping a record of all correspondence relating to the project including information on the 106 agencies contacted to recruit ‘tribe’ members and conduct health education workshops. This documentation included the advertising and recruitment processes used to recruit ‘tribe’ members/peer educators.

Most of this documentation was kept for accountability reasons, but a significant motivation for such detailed documentation (as stated by many of the ‘tribe’ members/peer educators) was the hope that it would assist others who may wish to conduct a similar project in the future. The ‘tribe’ members/peer educators stated that
‘this could help others avoid some of the mistakes and fuck-ups we made, especially at the beginning of the project’.

**Resource utilisation**

The project utilised a series of health education resources to find technical information on BBV and STI transmission. ‘Rave Safe’ was used for information on drug use and harm reduction issues. However, the project drew on the life experiences of both the project worker and the ‘tribe’ members/peer educators to provide contexts for the provision of this information. This made the scenarios, questions and demonstrations in ‘The Game’ much more realistic and closer to real-life experiences. This was an important factor in the credibility and acceptability of the workshops and resource with the target group.

The ‘tribe’ members/peer educators also created much of the materials they used to develop and produce the resource. For example, they drafted and drew up the design for the board game. They made the spinning tool for playing ‘The Game’. They came up with the imagery and iconography used in ‘The Game’ drawing on their real life experiences.